Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01501

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Ward Washington Jr.
2. Date of Death: Month: January Day: 20 Year: 2001
3. Time of Death: 0210
4a. Facility Name (If not institution, give street and number): Good Samaritan Hosp.
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 250-50-3361
6. Sex: 1 ☒ M 2 ☐ F
7. Age (in yrs. last birthday): 64 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4-16-1936
9. Birthplace (State or Foreign Country): S.C

Usual Residence of Decedent

10a. State: Md.
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 2221 Westfield Ave
10f. Zip Code: 21214
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th grade; College (1-4or 5+): n/a
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver
16b. Kind of Business/Industry: Truck Driver

17. Father's Name (First, Middle, Last): George W. Washington Sr.
18. Mother's Name (First, Middle, Maiden Surname): Lula Grant

19a. Informant's Name/Relationship (Type, Print): Martha Washington (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2221 Westfield Ave. Balto. Md. 21214

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Mem. Pk. Date: 1/24/2001
20c. Location - City or Town, State: Arbutus Md.

21. Signature of Funeral Service Licensee: Patricia Betts
22. Name and Address of Facility: Betts Funeral Home 1124 N. Caroline St. Balto. Md. 21213

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediata Causa (Final disease or condition resulting in death) a.	Acute Myocardial Infarction	1 hr
Dua to (or as a consequance of): b.	Cormary artery disease	1 yr
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequanca of): c.	Diabetes Mellitus	20yrs
Due to (or as a consequenca of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

End stage Renal Disease

Atrial Fibrillation

Hypertension

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA. Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Hyung Lim MD
29c. License number: D 46907
29d. Date signed (Month, Day, Year): January 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Hyung Lim 5601 Loch Raven Blvd Baltimore MD 21239

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001
32. Registrar's Signature: Steve G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01502

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lillian Wiese
2. Date of Death (Month, Day, Year): January 11, 2001
3. Time of Death: 1:30 PM
4a. Facility Name (If not Institution, give street and number): Augsburg Lutheran Home
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 213-28-0261
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 98 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr 24, 1902
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6811 Campfield Road
10f. Zip Code: 21207
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 8
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): registered nurse
16b. Kind of Business/Industry: medicine

17. Father's Name (First, Middle, Last): Albert John Wiese
18. Mother's Name (First, Middle, Maiden Surname): Clara Schleuter

19a. Informant's Name/Relationship (Type, Print): Rosemary Dietz/niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4605 Benson Ave Baltimore, MD 21227

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Bacterial pneumonia	1 week
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year):
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred:
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):
28f. Location (Street and Number or Rural Route Number, City or Town, State):

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D37573
29d. Date signed (Month, Day, Year): January 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeff Zibell MD 25 Main Street Reisterstown MD 21136

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01503

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ellen F Williams
2. Date of Death (Month, Day, Year): Jan 22 2001
3. Time of Death: 8:10am

4a. Facility Name (If not institution, give street and number): 1207 Middleborough Road
4b. City, Town, or Location of Death: Essex
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 058-24-9804
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 17 1931
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 1207 Middleborough Road
10f. Zip Code: 21221
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Food Service Manager
16b. Kind of Business/Industry: School Cafeteria

17. Father's Name (First, Middle, Last): Joseph Patanella
18. Mother's Name (First, Middle, Maiden Surname): Sarah Kelly

19a. Informant's Name/Relationship (Type, Print): Kevin Williams /son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 103 Hampshire Road Baltimore Md 21221

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sacred Heart of Jesus | Date: 1/26/01
20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: R. Terry Connelly
22. Name and Address of Facility: Connelly Funeral HOme of Essex 300 MAce AVe. Baltimore Md. 21221

Physician Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. RENAL CELL CARCINOMA WITH
Due to (or as a consequence of): LIVER METASTASIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as e consequence of):
c. Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sein Aung
29c. License number: D 51555
29d. Data signed (Month, Day, Year): 01/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SEIN AUNG 9000 FRANKLIN SQUARE DRIVE, BALTIMORE MD 21237

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01504

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JANE GOLEMBIESKA WINKLER

2. Date of Death — Month: JAN. Day: 16 Year: 2001

3. Time of Death: 2:00AM

4a. Facility Name *(If not institution, give street and number)*: 7523 Kenlea Avenue

4b. City, Town, or Location of Death: Baltimore County

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-12-5553

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: Oct.28,1923

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore County

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7523 Kenlea Avenue

10f. Zip Code: 21236

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12 yrs.

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Stenographer

16b. Kind of Business/Industry: B. G. & E.

17. Father's Name *(First, Middle, Last)*: Stanislaus Golembieska

18. Mother's Name *(First, Middle, Maiden Surname)*: Victoria Kalinowska

19a. Informant's Name/Relationship *(Type, Print)*: Lingard E. Winkler (Husband)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7523 Kenlea Avenue Baltimore, Maryland 21236

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holy Rosary Cemetery

Date: 1-19-2001

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Lassahn Funeral Home 7401 Belair Rd. Baltimore, Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ventricular tachycardia — minutes

Due to (or as a consequence of):

b. with Hypertensive

Due to (or as a consequence of):

c. and High Blood Pressure

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Recent Hospitalization for Pneumonia.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. Licensa number: D27693

29d. Date signed *(Month, Day, Year)*: 1/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael A. Hyle,MD 6530 Walther Avenue Baltimore, Md. 21206

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 23 2001

32. Registrar's Signature

FEB 2 2001

ORIGINAL

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01505

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lewis Williams

2. Date of Death (Month, Day, Year): January 18, 2001

3. Time of Death: 1500

4a. Facility Name *(If not institution, give street and number)*: Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 243-50-7342

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 2/2/1937

9. Birthplace *(State or Foreign Country)*: North Caroline

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 335 Whitridge Ave

10f. Zip Code: 21218

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6th | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver

16b. Kind of Business/Industry: Baltimore city

17. Father's Name *(First, Middle, Last)*: Willie Williams

18. Mother's Name *(First, Middle, Maiden Surname)*: Katie Lewis

19a. Informant's Name/Relationship *(Type, Print)*: Barbara Williams-Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1628 Lyle Ct. 21234 Baltimore, maryland

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Garden of Methsemane | Date: 1/27/2001

20c. Location - City or Town, State: Rocky Mount, Northcarolina

21. Signature of Funeral Service Licensee: ▶ Geoffrey Miller

22. Name and Address of Facility: miller's metropolitan Chapel 1639 N. Broadway 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CVA — 8 days

Due to (or as a consequence of):

b. Congestive Heart failure — 10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Pneumonia — 14 days

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CAD

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Allen D. Garrison

29c. License number: P143877

29d. Date signed *(Month, Day, Year)*: January 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Allen Ca Garrison, Union Memorial Hospital, 201 E. University Parkway Baltimore MD 21218

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001

32. Registrar's Signature: ▶ Bernice G Sparks

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01506

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILLIAM J. YEAGER, JR.

2. Date of Death — Month: JANUARY Day: 17 Year: 2001

3. Time of Death: 1145 P.M.

4e. Facility Name *(If not institution, give street and number)*: FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 220-05-8422

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: 7-19-1918

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10e. State: Maryland

10b. County: Baltimore City

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 6607 Moyer Avenue

10f. Zip Code: 21206

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12 yrs.

College (1-4or 5+): 2 yrs.

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Project Manager

16b. Kind of Business/Industry: Construction Industry

17. Father's Name *(First, Middle, Last)*: William J. Yeager, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Lillian Bransby

19a. Informant's Name/Relationship *(Type, Print)*: Ruth B. Yeager (Wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6607 Moyer Avenue Baltimore, Md. 21206

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Moreland Memorial Pk.

Date: 1-20-01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Ronald C. Eberstein

22. Name and Address of Facility: Lassahn Funeral Home 7401 Belair Rd. Baltimore, Maryland 21236

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. End Stage Cardiomyopathy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J Krolikowski D.O.

29c. License number: 203315

29d. Date signed *(Month, Day, Year)*: 1/17/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR JEANETTE KROLIKOWSKI 9000 FRANKLIN SQUARE DR. BALTIMORE MARYLAND 21237

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 23 2001

32. Registrar's Signature: Maura B. Jones

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

William Yeager

ax1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM 5 per fh G794 041101 SS

Certificate of Death

Reg. No: 2001 01507

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LANCE R. ARNDT

2. Date of Death: Month January Day 4, Year 2001

3. Time of Death: 7:50 P.M.

4a. Facility Name (If not institution, give street and number): 4146 Crisfield Highway

4b. City, Town, or Location of Death: Crisfield

4c. County of Death: Somerset

Funeral Director

5. Social Security Number: ~~220-68-7644~~ 220-68-7649

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 43 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 28, 1957

9. Birthplace (State or Foreign Country): Michigan

Usual Residence of Decedent

10a. State: Maryland

10b. County: Somerset

10c. City, Town or Location: Crisfield

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4146 Crisfield Highway

10f. Zip Code: 21817

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Richard Arndt

18. Mother's Name (First, Middle, Maiden Surname): Carolyn Louise Hickman

19a. Informant's Name/Relationship (Type, Print): Janice D. Arndt (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4146 Crisfield Highway - Crisfield, MD 21817

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Sunnyridge Memorial Park

Date: 1/8/01

20c. Location - City or Town, State: Crisfield, MD

21. Signature of Funeral Service Licensee: Robert H. Bradshaw, Jr.

22. Name and Address of Facility: Bradshaw & Sons Funeral Home, 306 W. Main St.- Crisfield, MD 21817

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. LUNG CANCER — 3 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Natesan

29c. License number: D051359

29d. Date signed (Month, Day, Year): January 8/15 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Usha Natesan, M.D. - 12208 Brittingham Lane - Princess Anne, MD 21853

State Registrar

31. Date filed (Month, Day, Year): JAN 8 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 29d per M.E.
01/09/2001, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01508

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
John Carlton Bowen, Jr.	Jan 06 2001	6:19pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Carroll County General Hospital	Westminster	Carroll

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-28-9796	1☒M 2☐F	68 Yrs.			Jun 22 1932	MD

Funeral Director

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Carroll	Westminster	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1210 Humbert Schoolhouse Rd	21158	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.)	14. Race - Amaricen Indian, Black, White, etc.
1☐Nevar Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yas 2☐No If Yas, Giva Yaar or Datas: 1950 1955	1☐Yas 2☒No Specify:	Specify: White

15. Decedent's Educetion (Specify only highast grada completed)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired)	16b. Kind of Business/Industry
Elamantary/Secondary (0-12)	Collega (1-4or 5+)	Sales	Superior Transfer

17. Fathar's Nama (First, Middle, Last)	18. Mothar's Nama (First, Middle, Maiden Sumama)
Julian Carlton Bowen	Elizabeth Virginia Kimes

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 21158
Sharon Bowen/wife	1210 Humbert Schoolhouse Rd Westminster, MD

20a. Mathod of Disposition	20b. Place of Disposition (Nama of cemetery, crametory or other piece)	Data	20c. Location - City or Town, Stata
1☐Burial 2☒Cramation 3☐Ramoval from Stata 4☐Donation 5☐Other (Specify)	Carroll Cremation, Inc	1/8/2001	Hampstead, MD

21. Signatura of Funaral Service Licensea	22. Nama and Addrass of Facility
▶ [signature]	Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD 21157

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on each line.

Approximata Intarval Between Onset and Death

Immediata Causa (Final diseasa or condition resulting in daath)
a. ASC VD — Minutes

Due to (or as a consequence of):

Sequantially list conditions, if any, laading to immadiata ceusa. Entar Underlying Ceusa (Diseasa or injury that initieted avents resulting in daath) Last
b.
Due to (or as a consequance of):
c.
Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Ware autopsy findings available prior to completion of ceuse of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case retarred to medicel examiner?	26. Place of Death (Check only one)	
1☒Yas 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Othar: 4☐Nursing Homa 5☐Residence 6☐Othar (Specify)

27. Manner of Death	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1☒Natural 2☐Accident 3☐Suicida 4☐Homicida 5☐Pending investigetion 6☐Could not be determined		M	1☐Yas 2☐No	

28a. Place of Injury - At homa, tarm, street, tactory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29e. Cartifiar (Check only one)
1☐ **Certifying Physician:** To tha best of my knowledge, deeth occurred at tha tima, data and plece, and due to the cause(s) end menner as stated.
2☒ **Medical Examiner:** On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) end mannar stated.

29b. Signature and title of certifiar	29c. License number	29d. Data signed (Month, Day, Year)
▶ [signature]	D0051924	January 7, 2001 ~~January 4, 2000~~

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)
Herbert P. Henderson Jr. MD 295 Stone Ave Suite 307 Westminster MD 21157

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signatura
JAN 09 2001	[signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 18 per F.D. 01/10/2001, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 01509

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
WILLIAM ELMER BOLLINGER, SR.	JAN. 8, 2001	11:15 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3917 GAMBER RD.	FINKSBURG	CARROLL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-12-0664	1☒M 2☐F	79 Yrs.			9/21/1921	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	CARROLL	FINKSBURG	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3917 GAMBER RD.	21048	USA.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.)	14. Race - Americen Indian, Bleck, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Yeer or Detes: WW II	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grede completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	Collage (1-4or 5+)		
7		PLUMBER	STATE HOSPITAL

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surneme)
HERBERT L. BOLLINGER, SR.	~~MARY SHIPLEY~~ ELSIE MAY SHIPLEY

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code)
SON WILLIAM E. BOLLINGER, JR.	3917 GAMBER RD., FINKSBURG, MD. 21048

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☒Buriel 2☐Cremetion 3☐Removal from State 4☐Donation 5☐Other (Specify)	PROVIDENCE CEMETERY	1/12/01	GAMBER, MD.

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in death)	a. Congestive Cardiomyopathy	1 YEAR
	Due to (or as a consequance of):	
Sequentiellly list conditions, if any, leading to immadiete ceusa. Entar Underlying Cause (Disaasa or Injury that initiated events resulting in death) Last	b. Ischemic Heart Disease	24 YEARS
	Due to (or es a consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causa of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of death?
1☐Yes 2☑No	1☐Yes 2☑No

25. Was casa referred to medicel examinar?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and menner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and dua to tha cause(s) and manner steted.

29b. Signature and title of certifier	29c. License number	29d. Deta signed (Month, Day, Year)
▶ [signature] INTERNIST	D 52035	Jan 9 2001

30. Name end eddress ot parson who completed cause of death (Item 23a) (Type, Print)
BINU CHACKO 291 Stoner Avenue Westminster MD 21157

State Registrar

31. Dete filed (Month, Day, Year)	32. Registrar's Signature
JAN 10 2001	▶ [signature] G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item#20b, per f.h.,1/9/01, bg

Certificate of Death

Reg. No. 2001 01510

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
George	Howeth	Barnes	January	01	2001	1:40AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Manokin Manor	Princess Anne	Somerset

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-09-8271	1☒M 2☐F	96 Yrs.					10/22/1904	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Somerset	Princess Anne	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
30744 Perry Road	21853	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.)	14. Race - American Indian, Black, White, atc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highast grade completed)		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Clerk	Post Office

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Gordon Handy Barnes	Lelia Mae Howeth

19a. Informant's Name/Relationshlp (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Jean L. Barnes/Wife	30744 Perry Road, Princess Anne, Md. 21853

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other placa)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Salisbury Crematory	01/03/~~00~~	Salisbury, Md.

21. Signatura of Funaral Servica Licansaa	22. Name and Address of Facility
▶ James L. Hinman M00295	Hinman Funeral Home 11673 Somerset Ave., Princess Anne, Md. 21853

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disaase or condition resulting in death)	a. ASCVD	
	Due to (or as a consequence of):	
	b. CHF	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequenca of):	
	c. AFib	
	Due to (or as a consequenca of):	
	d. CVA	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signatura and litie of certifiar	29c. Licansa number	29d. Data signad (Month, Day, Year)
▶ MKW MD	047044	1/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NATESAN V. 106 PINE BLUFF ROAD #12 SALISBURY MD 21801

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 3 2001	▶ G. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Barnes

George H.

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01511

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Chase Cordery

2. Date of Death: Month JANUARY Day 2 Year 2001

3. Time of Death: 1530

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 168-20-5732

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 21 1925

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1802 Somers Drive

10f. Zip Code: 21804

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: None

17. Father's Name (First, Middle, Last): Abraham Chase

18. Mother's Name (First, Middle, Maiden Surneme): Benena Limberry

19a. Informant's Name/Relationship (Type, Print): Wilhelmina Williams (Daughter)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 18454 Melrose, Southfield MI 48075

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other place): Green Acres

Date: 1/9/01

20c. Location - City or Town, State: Salisbury, Md.

21. Signature of Funeral Service Licensee: Eugene M. Stewart

22. Name and Address of Facility: Stewart Funeral Home 821 West Rd. Salisbury, Md. 21801

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final diseasa or condition resulting in death)

a. Cardiorespiratory Arrest — 35 minutes

Due to (or as a consequence of):

b. History of Aterial fibrillation

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: History of Breast Cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and titie of certifier: E. Edwards MD (Edwards)

29c. License number: D45485

29d. Date signed (Month, Day, Year): 1/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 100 E Carroll St. Salisbury MD 21801 S. EDWARDS, M.D.

State Registrar

31. Date filed (Month, Day, Year): JAN 08 2001

32. Registrar's Signature: Penny G. Sparks

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ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Elizabeth Cordery 168 20 5732

16DQ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01512

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John HENRY Cottman
2. Date of Death (Month, Day, Year): JANUARY 8, 2001
3. Time of Death: 0040
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 214-34-8326
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 09-15-35
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: SOMERSET
10c. City, Town or Location: MARION STATION
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4655 Rumbly Point RD
10f. Zip Code: 21838
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER
16b. Kind of Business/Industry: POULTRY INDUSTRY

17. Father's Name (First, Middle, Last): OSCAR Cottman
18. Mother's Name (First, Middle, Maiden Surname): HELEN F. JACKSON

19a. Informant's Name/Relationship (Type, Print): MARY A. WALKER | SISTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 30 Marion Station, MD 21838

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): EBENEZER U.M.C. Cemetery | Date: 01-13-01
20c. Location - City or Town, State: MARUMSCO, MD

21. Signature of Funeral Service Licensee: Anthony E. Ward
22. Name and Address of Facility: Anthony E. Ward Funeral Home 314 Code ST. Crisfield, MD 21817

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Laryngeal CANCER — 9 MONTHS
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: COPD

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D-39813
29d. Date signed (Month, Day, Year): 1/9/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARKINS 100 Healthway Drive Salisbury MD 21804

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

John Cottman 214-34-8326

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended#4,01-10-01,WCHD,DQ

Certificate of Death

Reg. No. 2001 01513

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGARET DENNIS
2. Date of Death (Month, Day, Year): JANUARY 6 2001
3. Time of Death: 655 Am
4a. Facility Name (If not institution, give street and number): DEER'S HEAD CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: ~~220-01-9133~~ ~~218-20-2809~~
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-24-1915
9. Birthplace (State or Foreign Country): Va.

Usual Residence of Decedent

10a. State: Md.
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1☒ Yes 2☐ No
10a. Street and Number: Emerson Avenue
10f. Zip Code: 21801
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress
16b. Kind of Business/Industry: Clothing Store

17. Father's Name (First, Middle, Last): Norman Adkins
18. Mother's Name (First, Middle, Maiden Surname): Ethel Butler Adkins

19a. Informant's Name/Relationship (Type, Print): Bonita Hudson, Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 308 E. Elizabeth St. Delmar, Md. 21875

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Stephens Cemetery
Date: 1-9-2001
20c. Location - City or Town, State: Delmar, De.

21. Signature of Funeral Service Licensee: ▶ William M. Short Jr.
22. Name and Address of Facility: Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only one* cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CONGESTIVE HEART FAILURE	45 days
Due to (or as a consequence of):	b. ARTERIOSCLEROTIC CARDIOVASCULAR	YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. HYPERTENSION	YEARS
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS - 2

ANEMIA

MORBID OBESITY

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Virginia A. DuLany MD
29c. License number: D33905
29d. Date signed (Month, Day, Year): 1/6/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VIRGINIA A. DULANY MD PO BOX 2018 SALISBURY MD 21802-2018

State Registrar

31. Date filed (Month, Day, Year): JAN 08 2001
32. Registrar's Signature: ▶ Penny B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

404

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01514

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Paul Richard Eichman
2. Date of Death (Month, Day, Year): January 4 2001
3. Time of Death: 1:40PM
4a. Facility Name *(If not institution, give street end number)*: Carroll County General Hospital
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 213-46-0391
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 60 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Date of Birth *(Month, Day, Year)*: Nov. 5, 1940
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10e. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Union Bridge
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 314 Thomas St.
10f. Zip Code: 21791
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: music teacher
16b. Kind of Business/Industry: public school

17. Father's Name *(First, Middle, Last)*: Paul Eichman
18. Mother's Name *(First, Middle, Maiden Surname)*: Lenore Lindsay

19a. Informant's Name/Relationship *(Type, Print)*: Margaret Ellis/ sister
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2809 Westgate Easton, PA 18040

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mountain View Cemetery
Date: 1/8/01
20c. Location - City or Town, State: Union Bridge, MD

21. Signature of Funeral Service Licensee: Catharine D. Hartzler
22. Name and Address of Facility: Hartzler Funeral Home 6 E. Broadway Union Bridge, MD 21791

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Melanoma	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☑ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Catharine D. Hartzler
29c. License number: D51072
29d. Date signed *(Month, Day, Year)*: 1/4/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHARON Taylor Hallman, MD 200 Memorial Ave. Carroll County General Hospital, Westminster, MD 21157

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 09 2001
32. Registrar's Signature: Jeanne G Sparks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Eichman Richard Paul

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 01515

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Roland E. Feeser

2. Date of Death (Month, Day, Year): Jan 06 2001

3. Time of Death: 8:00pm

4a. Facility Name *(If not institution, give street and number)*: 842 Littlestown Pike

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 217-03-5300

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec 31 1920

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1 ☐ Yes 2 ☐ No XX

10e. Street and Number: 842 Littlestown Pike

10f. Zip Code: 21158

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☐ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner/Operator

16b. Kind of Business/Industry: Feesers Fruit Market

17. Father's Name *(First, Middle, Last)*: Harry F. Feeser

18. Mother's Name *(First, Middle, Maiden Surname)*: Bernetta R. Myers

19a. Informant's Name/Relationship *(Type, Print)*: Dale Feeser/son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 842 Littlestown Pk Westminster, MD 21158

20a. Method of Disposition: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Pleasant Valley Cem | Date: 1/10/2001

20c. Location - City or Town, State: Pleasant Valley, MD

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: Pritts Funeral Home and Chapel 412 Washington Road Westminster, MD21157

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert tailure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. multi infarct demntia — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en autopsy performed? 1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 ☐ Yes 2 ☐ No

25. Was cese referred to medical examiner? 1 ☐ Yes 2 ☐ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 4 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶

29c. License number: D53165

29d. Date signed *(Month, Day, Year)*: 1/8/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Steven Shaffer 2111 Hanover Pike Hampstead MD 21074

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 09 2001

32. Registrar's Signature: Bonnie G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 5 per F.D.
01/17/01/Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01516

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edith Farver
2. Date of Death Month / Day / Year: January 6 2001
3. Time of Death: 10:20pm
4a. Facility Name *(If not Institution, give street and number)*: Westminster Nursing Center
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. ~~220-07-3848~~ 218-09-7868
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan 3 1913
9. Birthplace *(State or Foreign Country)*: Md

Usual Residence of Decedent

10a. State: Md
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1234 Washington Road
10f. Zip Code: 21157
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: homemaker
18b. Kind of Business/Industry: domestic

17. Father's Name *(First, Middle, Last)*: George Gist
18. Mother's Name *(First, Middle, Maiden Surname)*: Ethel Rydeninger

19a. Informant's Name/Relationship *(Type, Print)*: Richard Farver (son)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 526 Buckhorn Rd.,Sykesville, Md 21784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Ebenezer UMC Cemetery
Date: 1-10-01
20c. Location - City or Town, State: Woodbine, Md

21. Signature of Funeral Service Licensee: ▶ Paige Haight Herbert
22. Name and Address of Facility: Haight Funeral Home & Chapel, P.O. Box 195 Sykesville, Md 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	CVA	3wk
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	ASCVD	20yr
Due to (or as a consequence of):		
c.	HPTN	15yr
Due to (or as a consequence of):		
d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ John W. Middleton
29c. License number: D25443
29d. Date signed *(Month, Day, Year)*: 1/8/2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): John W. Middleton 688 Poole Rd, Westminster Md 21157

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 09 2001
32. Registrar's Signature: ▶ Penna G Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01517

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: James Francis Frazier
2. Date of Death Month Day Year: JAN. 10, 2001
3. Time of Death: 1:10 PM
4a. Facility Name *(If not institution, give street and number)*: 4402 Harmony Road
4b. City, Town, or Location of Death: Preston
4c. County of Death: Caroline

Funeral Director

5. Social Security Number: 214-18-2040
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sep.6,1918
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Caroline
10c. City, Town or Location: Preston
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4402 Harmony Road
10f. Zip Code: 21655
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Shipping Clerk/Machinist
16b. Kind of Business/Industry: Manufacturing

17. Father's Name *(First, Middle, Last)*: Thomas Francis Frazier
18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth Holmes

19a. Informant's Name/Relationship *(Type, Print)*: Elsie Frazier/Spouse
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4402 Harmony Rd., Preston, MD 21655

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Farmers Church Cem.
Date: 1/15/01
20c. Location - City or Town, State: Preston, Maryland

21. Signature of Funeral Service Licensee: ▶ Michael F. Eskow
22. Name and Address of Facility: Framptom-Hawkins-Eskow Funeral Home, PA PO Box 43, Federalsburg, MD 21632

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Non small cell lung Cancer — 3½ months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D35887
29d. Date signed *(Month, Day, Year)*: 1/10/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): David Smith, M.D. 29466 Pintail Dr., Suite 5, Easton, MD 21601

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Recois, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01518

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sonya Felipe

2. Date of Death: Month January Day 8 Year 2001

3. Time of Death: 956 pm

4a. Facility Name (If not institution, give street and number): University of Maryland Medical Systems

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 476-30-2092

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): October 30, 1932

9. Birthplace (State or Foreign Country): Minnesota

Usual Residence of Decedent

10a. State: Maryland

10b. County: Caroline

10c. City, Town or Location: Denton

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1000 South Second Street

10f. Zip Code: 21629

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Albert Fectzo

18. Mother's Name (First, Middle, Maiden Surname): Fredia Mitzi Schwartz

19a. Informant's Name/Relationship (Type, Print): Dr. Philip P. Felipe Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1000 South Second Street, Denton, Maryland 21629

20a. Method of Disposition: ☒ 1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Cross Cemetery

Date: 1/12/01

20c. Location - City or Town, State: near Greensboro, MD

21. Signature of Funeral Service Licensee: Randolph P. Moore

22. Name and Address of Facility: Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	3 days
Due to (or as a consequence of):	b. ischemic bowel	3 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Respiratory failure	3 days
Due to (or as a consequence of):	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Systemic lupus

Coronary artery disease

23b. Did tobacco use contribute to the cause of death?

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): ☒ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. ☐ 2 Medical Examiner: On the basis of examinetion and/or Investigetion, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: C. Closson

29c. License number: 12488

29d. Date signed (Month, Day, Year): January 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Greg-Walter Closson, M.D. 22 South Greene St, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01519

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: PAULINE WYNNE GREENE

2. Date of Death (Month, Day, Year): January 9, 2001

3. Time of Death: 7:11AM

4a. Facility Name *(If not institution, give street and number)*: 4425 Clayton Court

4b. City, Town, or Location of Death: Waldorf

4c. County of Death: Charles

Funeral Director

5. Social Security Number: 044-32-1357

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JAN 23 1938

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Charles

10c. City, Town or Location: Waldorf

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4425 Clayton Court

10f. Zip Code: 20601

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: School Teacher

16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: James Wynne

18. Mother's Name *(First, Middle, Maiden Surname)*: Valena Gainey Wynne

19a. Informant's Name/Relationship *(Type, Print)*: Elbert M. Greene Sr (husband)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4425 Clayton Court Waldorf, Maryland 20601

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Resurrection Cem. | Date: 1-13-01

20c. Location - City or Town, State: Clinton, MD

21. Signature of Funeral Service Licensee: John A. Eberwein M00173

22. Name and Address of Facility: Eberwein Funeral Services, 4433 White Pls. La. White Pls., MD 20695

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lung Cancer with metatasis	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Krishan M. Mathur

29c. License number: D28352

29d. Date signed *(Month, Day, Year)*: January 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Krishan Mathur, MD., P.O. Box 1703, La Plata, MD 20646

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

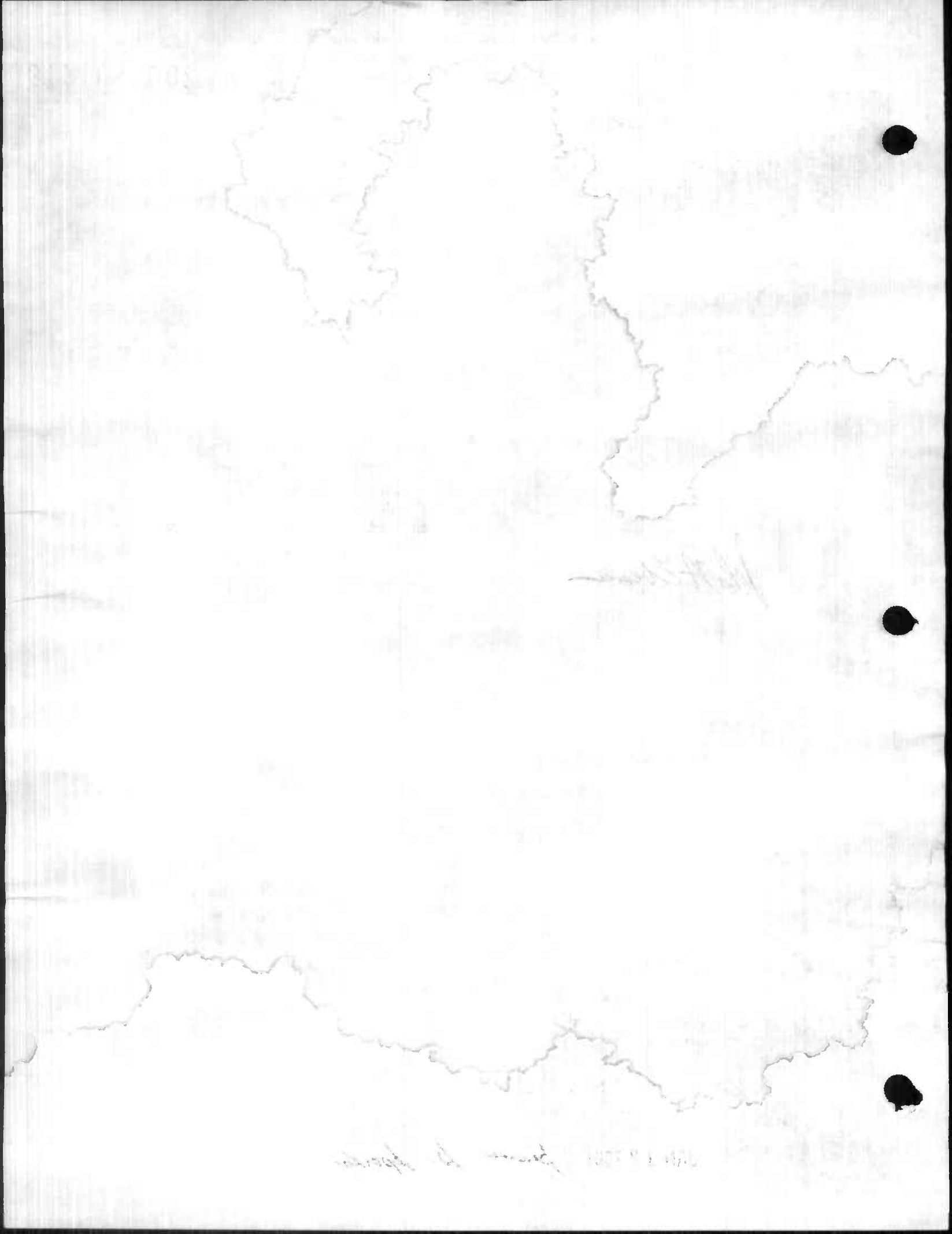
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01520

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lewis Gilbert
2. Date of Death Month Day Year: January 5 2001
3. Time of Death: 2:16AM
4a. Facility Name *(If not institution, give street and number)*: Long View Nursing Home
4b. City, Town, or Location of Death: Manchester
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 215-14-1636
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 78 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 2, 1922
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 714 Deer Park Road
10f. Zip Code: 21157
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Machinest / Barber
16b. Kind of Business/Industry: Textile - Hygiene

17. Father's Name *(First, Middle, Last)*: Lewis Frank Gilbert
18. Mother's Name *(First, Middle, Malden Surname)*: Florrie Bennett

19a. Informent's Name/Reletionship *(Type, Print)*: Mrs. Martha S. Gilbert (Wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 714 Deer Park Road Westminster, MD 21157

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Deer Park UMC Cemetery — Date: 1/8/01
20c. Location - City or Town, State: Westminster, MD

21. Signature of Funeral Service Licensee: Brian L. Haight
22. Name and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL, P.A. (Box 195) Sykesville, MD 21784 (410)-795-1400

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — 1 wk

Due to (or es a consequenca of):
b. Alzheimers Disease — 5yrs

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or es a consequence of):
c. ASCVD — 20yr

Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] inpatient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Neturai 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Dete of injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office buliding, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and piace, and due to the cause(s) and manner es stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date end piace, and due to the cause(s) and manner steted.

29b. Signeture and titie of certifier: John Middleton
29c. License number: D25443
29d. Dete signed *(Month, Day, Year)*: 1/5/2001

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): John W. Middleton 688 Poole Road, Westminster Md 21157

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 09 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet tha death certificata be executed within 24 hours eftar death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 18 per F.D. 01/09/2001, Carroll County, wj1

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01521

Gubernatis, Thomas

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name *(First, Middle, Last)*: Thomas Frank Gubernatis Sr.

2. Date of Death Month / Day / Year: January 6 2001

3. Time of Death: 10:10 P.M.

4a. Facility Name *(If not institution, give street and number)*: Carroll County General Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll County

5. Social Security Number: 215-46-8721

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 53 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept 16 1947

9. Birthplace *(State or Foreign Country)*: Md

Usual Residence of Decedent

10a. State: Md

10b. County: Carroll

10c. City, Town or Location: Sykesville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 5915 Forest Court

10f. Zip Code: 21784

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Viet Nam

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: electrical buyer

16b. Kind of Business/Industry: Brown-Heim Electric

17. Father's Name *(First, Middle, Last)*: Elmer C. Gubernatis

18. Mother's Name *(First, Middle, Maiden Surname)*: ~~Agnes Gubernatis~~ Agnes Haupt

19a. Informant's Name/Relationship *(Type, Print)*: Susan Gubernatis (spouse)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5915 Forest Ct., Sykesville, Md 21784

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lake View Memorial

Date: 1-10-01

20c. Location - City or Town, State: Sykesville, Md

21. Signature of Funeral Service Licensee: ▶ Brian L. Haight

22. Name and Address of Facility: Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md 21784

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis — days

Due to (or as a consequence of):
b. metastatic melanoma — months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Hwan Young Yoo, M.D.

29c. License number: D0053514

29d. Date signed *(Month, Day, Year)*: January, 6, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Hwan Y. Yoo, M.D. 200 Memorial Ave. Carroll County General Hospital, Westminster, Maryland 21157

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 09 2001

32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01522

Harry Hall - 214-30-0939

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HARRY WESLEY HALL
2. Date of Death Month Day Year: January 4, 2001
3. Time of Death: 1354
4a. Facility Name *(If not institution, give street end number)*: PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 214-30-0939
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 14, 1911
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Worcester
10c. City, Town or Location: Berlin
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 636 Ocean Parkway-Ocean Pines
10f. Zip Code: 21811
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Yaer or Detes: Army
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.): 1☐Yes 2☒No *Specify:*
14. Rece - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade compieted)*: Elementery/Secondery (0-12): 8 | College (1-4or 5+): -
16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Owner/operator
16b. Kind of Business/Industry: Gas-Service Station

17. Fether's Nema *(First, Middle, Last)*: Wesley B. Hall
18. Mother's Neme *(First, Middle, Maiden Surname)*: Elizabeth Mitchell

19a. Informent's Neme/Reletionship *(Type, Print)*: Norma B. Hall/Wife
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stata, Zip Code)*: 636 Ocean Parkway-Ocean Pines, Berlin, MD 21811

20e. Method of Disposition: 1☒Buriel 2☐Cremetion 3☐Remuvel from Stete 4☐Donetion 5☐Other *(Specify)*
20b. Piece of Disposition *(Nama of cametery, crematory or othar piece)*: Fort Lincoln Cemetery
Data: 1/9/01
20c. Location - City or Town, Stata: Brentwood, MD

21. Signature of Funeral Service Licensee: D. M. Holloway
22. Name end Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part I. Entar the disease, or complicetions thet caused the death. Do not enter the moda of dying, such es cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line.

Approximete Intervel Between Onset and Death

Immediete Cause (Final disaesa or condition resulting in death)
a. Cardiogenic Shock — hr
Due to (or as e consequenca of):
b. Acute Anterior Myocardial Infarction — days
Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Causa (Disease or Injury that initieted evants rasulting in death) Last
Due to (or es e consequenca of):
c. Myocardial Infarction — yr
Due to (or as a consequance of):
d. CAD — yr

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Wes an autopsy performed? 1☐Yas 2☒No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Wes case referred to medical examiner? 1☐Yes 2☒No
26. Place of Deeth *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Deeth: 1☒Naturel 2☐Accident 3☐Suicida 4☐Homicide 5☐Panding investigetion 6☐Could not be datarmined
28a. Piece of Injury - At homa, farm, street, fectory, offica building, etc. *(Specify)*
28e. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Dascribe how injury occurred
28f. Location *(Street and Number or Rural Route Number, City or Town, Steta)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To tha best of my knowledga, daeth occurred et the time, date end place, and dua to tha cause(s) and mannar as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred et the time, data and ptace, and dua to the cause(s) and mannar stated.
29b. Signature and title of certifier: Joseph Raffetto M.D.
29c. Licensa number: 20441
29d. Date signed *(Month, Day, Year)*: JANUARY 5, 2001

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Joseph Raffetto, M.D. 400 E Shore Dr. Salisbury, MD 21804

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 08 2001
32. Registrar's Signeture: Penny G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

7+1 DQ

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01523

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ESTHER JANE HEINTZ
2. Date of Death (Month, Day, Year): January 4, 2001
3. Time of Death: 2:20 PM
4a. Facility Name (If not institution, give street and number): Salisbury Center: Genesis ElderCare
4b. City, Town, or Location of Death: Salisbury
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 185-14-1244
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 4, 1922
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 200 Civic Ave.
10f. Zip Code: 21804
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): -
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Timekeeper
16b. Kind of Business/Industry: Steel

17. Father's Name (First, Middle, Last): John Beharka
18. Mother's Name (First, Middle, Maiden Surname): Helen Pastorek

19a. Informant's Name/Relationship (Type, Print): Cheryl Buchanan/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 27915 Cross Creek Dr., Salisbury, MD 21801

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Salisbury Crematory
Date: 1/5/01
20c. Location - City or Town, State: Salisbury, MD

21. Signature of Funeral Service Licensee: W R Holloway LFSD
22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ADVANCED ALZHEIMER'S DISEASE — 9 years

Due to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequance of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D39813
29d. Date signed (Month, Day, Year): 1/4/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Anastasia MD 1104 Healthcare Drive Salisbury MD 21804

State Registrar

31. Date filed (Month, Day, Year): JAN 08 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Esther Heintz
Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4
DQ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01524

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Leona May Henry

2. Date of Death (Month, Day, Year): Jan 4, 2001

3. Time of Death: 9:00 pm

4a. Facility Name (If not institution, give street and number): Golden Crest Geriatric Care Center

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 216-03-9126

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 16, 1917

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Hampstead

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4302 Black Rock Road

10f. Zip Code: 21074

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Shipping Department

16b. Kind of Business/Industry: Random House

17. Father's Name (First, Middle, Last): John Raymond Wilhelm

18. Mother's Name (First, Middle, Maiden Surname): Clara Belle Zencker

19a. Informant's Name/Relationship (Type, Print): Jeanne Shaffer, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4810 Westfield Dr, Hampstead, MD 21074

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Beckleysville Cemetery

Date: 01/08/2001

20c. Location - City or Town, State: Hampstead, MD

21. Signature of Funeral Service Licensee: Steven W Eline MD0723

22. Name and Address of Facility: Eline Funeral Home, 934 South Main St, Hampstead, MD 21074

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Alzheimers Disease — 3yrs

Due to (or as a consequence of):
AS CVD — 15yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) ASSISTED LIVING

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Middleton

29c. License number: D25443

29d. Date signed (Month, Day, Year): 1/5/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John W. Middleton 688 Poole Rd, Westminster, Md 21157

State Registrar

31. Date filed (Month, Day, Year): JAN 05 2001

32. Registrar's Signature: Denise G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 25a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01525

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BERNICE MARIE HELLER
2. Data of Death (Month, Dey, Year): JAN. 5, 2001
3. Tima of Death: 5:30 AM
4a. Facility Nema (If not institution, giva street and number): BROOKFIELD MANOR
4b. City, Town, or Location of Death: MIDDLEBURG
4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 230-24-2222
6. Sax: 1☐ M 2☒ F
7. Aga (In yrs. last birthday): 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Deta of Birth (Month, Day, Year): 12/18/1925
9. Birthplace (State or Foraign Country): VIRGINIA

Usual Rasidanca of Decedant

10a. State: MD.
10b. County: CARROLL
10c. City, Town or Location: HAMPSTEAD
10d. Insida City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3390 RESH MILL RD.
10f. Zip Coda: 21074
10g. Citizen of What Country?: USA.

11. Meritel Statua: 1☐ Naver Merried 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forcas?: 1☒ Yes 2☐ No — If Yas, Giva Yeer or Deles: WWII
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.): 1☐ Yas 2☒ No Specify:
14. Race - American Indian, Black, Whita, atc. Specify: WHITE

15. Decedant's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): NURSE
16b. Kind of Business/Industry: HEALTH

17. Fathar's Nama (First, Middla, Last): HOMER ELLSWORTH MONGER
18. Mothar's Name (First, Middla, Maidan Sumama): LAURA PEARL HENSLEY

19a. Informant's Name/Reletionship (Type, Print): LAURA LYNN HELLER-DAUGHTER
19b. Mailing Addrass (Straat and Number or Rurel Route Number, City or Town, Stata, Zip Code): 3390 RESH MILL RD.,HAMPSTEAD, MD. 21074

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Nema of cemetary, cramatory or othar piece): METRO CREMATORY — Date: 1/6/01
20c. Location - City or Town, Stata: BALTIMORE, MD.

21. Signature of Funaral Service Licansaa: Thom D. Fle
22. Name and Addrass of Facility: FLETCHER FUNERAL HOME, 254 E. MAIN ST., WESTMINSTER, MD. 21157

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha mode of dying, such as cardiac or raspiratory errest, shock, or haart failura. List only ona causa on aach line. — Approximata Interval Batween Onset and Daath

Immediata Causa (Final disaasa or condition rasulting in daath): a. metastatic breast cancer — ~ 22yrs.
Dua to (or as a consequance of):
Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Diseasa or injury that initiated avants rasulting in daath) Last: b.
Dua to (or as a consequance of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Were eutopsy findings available prior to compiation of cause of daath? 1☐ Yas 2☐ No

25. Was casa rafarred to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death (Check only ona): Hospitel: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) ASSISTED LIVING

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined
28a. Dete of Injury (Month, Day Year)
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify)
28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, daath occurred at tha tima, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of exeminetion and/or invastigetion, in my opinion, deeth occurred at the tima, dete and place, and dua to tha causa(s) and mannar stated.

29b. Signature and tita of certifiar: Paul Chang, MD
29c. Licanse number: D16587
29d. Date signed (Month, Day, Year): Jan 5/2001

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print): Paul Chang, MD 5601 Loch Raven Blvd, Baltimore, MD 21239

State Registrar

31. Date filed (Month, Day, Year): JAN 08 2001
32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item 27 per Phy. 01/09/2001, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01526

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard A. Healey, JR.
2. Data of Death — Month: January Day: 4 Year: 2001
3. Time of Death: 18:31
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 217-46-4504
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 53 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 8 1947
9. Birthplace (State or Foreign Country): Md

Usual Residence of Decedent

10a. State: Fla.
10b. County: Lee
10c. City, Town or Location: Bonita Springs
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 28710 Diamond Drive Unit 103
10f. Zip Code: 34134
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): electrical wirer
16b. Kind of Business/Industry: Lucent Technologies

17. Father's Name (First, Middle, Last): Richard Healey
18. Mother's Name (First, Middle, Maiden Surname): Margaret Wiel

19a. Informant's Name/Relationship (Type, Print): Linda Gaske (sister)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2731 Bevridge Dr., Marriottsville, Md 21104

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): All County Cremation — Date: 1-10-01
20c. Location - City or Town, State: Sykesville, Md

21. Signature of Funeral Service Licensee: Brian L Haight
22. Name and Address of Facility: Haight Funeral Home & Chapel, P.O. Box 195 Sykesville, Md 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Bilateral ACA, right mCA, left caudate infarcts	5 days
Due to (or as a consequence of): b.	Bilateral Cerebral edema	1 day
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one) — Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD.
29c. License number: RES-000
29d. Date signed (Month, Day, Year): January 4 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THE JOHNS HOPKINS HOSPITAL
Jianxin Ma 600 N. Wolfe St Baltimore MD 21287

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01527

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GLADYS M. HANDY
2. Date of Death — Month: 1 Dey: 1 Year: 01
3. Time of Death: 5AM
4a. Facility Name *(If not institution, give street and number)*: McCREADY HOSPITAL
4b. City, Town, or Location of Death: CRISFIELD
4c. County of Death: SOMERSET Co.

Funeral Director

5. Social Security Number: 220-03-6223
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs.
If Under 1 Year — Months: Deys:
If Under 24 Hrs. — Hours: Min.:
8. Date of Birth *(Month, Day, Year)*: 08/28/1916
9. Birthplace *(State or Foreign Country)*: VA

Usual Residence of Decedent

10a. State: MD
10b. County: Sommerset
10c. City, Town or Location: Upper Fairmount
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: P.O. Box 211
10f. Zip Code: 21867
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☒ Nevar Merried 2☐ Merried 3☐ Widowed 4☐ Divorced
12. Wes Decedant Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaer or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indien, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Spacify only highest grade completed)*: Elemantary/Secondery (0-12): 8th; College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: LABORER
16b. Kind of Business/Industry: Seafood

17. Fether's Neme *(First, Middle, Last)*: WEST HANDY
18. Mother's Name *(First, Middle, Meiden Surname)*: Sarah Brown Lewis

19a. Informent's Name/Relationship *(Type, Print)*: Tyvolia Holden - cousin
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: P.O. Box 76 Marion, MD 21838

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or othar piece)*: Handy's Memorial Cemetery
Date: 1-6-01
20c. Location - City or Town, Stete: Upper Hill, MD

21. Signature of Funarel Service Licensee: Anthony E. Ward
22. Name and Address of Facility: Anthony E. Ward Funeral Home 30639 Hampden Ave Princess Anne, MD. 21853

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the deeth. Do not enter tha moda of dying, such as cardiac or respiretory errest, shock, or haart failure. List only one causa on aach line.

Approximata Intarval Between Onset and Deeth

Immediete Ceuse (Finel diseesa or condition resulting in deeth)
e. Cardiorespiratory Arrest

Due to (or as a consequence of):
b. Acute Myocardial Infarction

Sequentielly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest

Due to (or as a consequence of):
c. Coronary Atherosclerosis

Due to (or as a consequence of):
d. Hypertension

Pert ii. **Othar significent conditions** contributing to death but not resulting in the underlying cause given in Pert i.
Diabetes Mellitis Type II.
Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings availabla prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa referred to medical axaminer? 1☐ Yes 2☑ No
26. Piece of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of injury *(Month, Dey Year)*
28b. Time of injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Phyeiclen:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medicat Exeminer:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end piece, end due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier: W. Gill MD
29c. License number: D00 15715
29d. Dete signed *(Month, Dey, Year)*: 1.1.01

30. Neme end eddress of person who completed cause of deeth (item 23e) (Type, Print): WILLIAM GILL MD 26423 BURTON AVE. CRISFIELD MD. 21817

State Registrar

31. Dete filed *(Month, Dey, Year)*: JAN 4 2001
32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by tha funeral director, page 2 should be detached for usa as the buriel-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01528

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anna Elizabeth Houlihan
2. Date of Death (Month, Day, Year): January 3, 2001
3. Time of Death: 10:40 PM
4a. Facility Name (If not institution, give street and number): 30360 Maple Street Apt. 303
4b. City, Town, or Location of Death: Princess Anne
4c. County of Death: Somerset

Funeral Director

5. Social Security Number: 141-03-6717
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02/28/1918
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: MD
10b. County: Somerset
10c. City, Town or Location: Princess Anne
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 30360 Maple Street Apt. 303
10f. Zip Code: 21853
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): None
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Harold Jones
18. Mother's Name (First, Middle, Maiden Surname): Catherine McGovern

19a. Informant's Name/Relationship (Type, Print): Carol Johnsen/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2839 Stockton Road, Pocomoke City, Md. 21851

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Salisbury Crematory | Date: 1/5/01
20c. Location - City or Town, State: Salisbury, MD

21. Signature of Funeral Service Licensee: James L. Hinman M00295
22. Name and Address of Facility: Hinman Funeral Home, 11673 Somerset Ave., Princess Anne, Md. 21853

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Metastatic breast Cancer	4 yrs
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph M. Grasso MD
29c. License number: D20507
29d. Date signed (Month, Day, Year): 1/4/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Joseph M. Grasso 145 E. Carroll St Salisbury MD

State Registrar

31. Date filed (Month, Day, Year): JAN 5 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend#22,01-08-01,WCHD,DQ

Certificate of Death

Reg. No. 2001 01529

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jesse LeRoy Jackson

2. Date of Death Month: 01 Day: 07 Yaar: 01

3. Time of Death: 11 AM

4a. Facility Name (If not institution, giva streat and number): 31945 Pembroke Court

4b. City, Town, or Location of Death: Delmar

4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 220-28-0990

6. Sax: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 66 Yrs.

If Undar 1 Yaar: Months / Days

If Undar 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Dey, Yaar): Mar. 1 1934

9. Birthplace (Stata or Foreign Country): Maryland

Usual Residence of Decedant

10a. Stata: Maryland

10b. County: Wicomico

10c. City, Town or Location: Delmar

10d. Insida City Limits: 1 [ ] Yas 2 [X] No

10e. Street and Number: 31945 Pembroke Court

10f. Zip Code: 21875

10g. Citizan of Whet Country?: U.S.A

11. Maritel Status: 1 [ ] Navar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Dacedant Evar in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No. If Yas, Giva Yaar or Data: 1952-54

13. Wes Decedant of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxicen, Puerto Rican, etc.): 1 [ ] Yas 2 [X] No Specify:

14. Race - American Indian, Black, White, atc.: Specify: Black

15. Decedant's Education (Specify only highast grada complatad): Elamantary/Secondary (0-12): 12 / Collega (1-4or 5+):

16a. Decedant's Usuel Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired): Laborer

16b. Kind of Business/Industry: None

17. Fathar's Nama (First, Middle, Last): Sandy Jackson

18. Mothar's Name (First, Middla, Maidan Surnama): Mary Corbin

19a. Informant's Name/Relationship (Type, Print): Sally Jackson (Wife)

19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code): 31945 Pembroke Ct.Delmar,Md.21875

20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar (Spacify)

20b. Place of Disposition (Nama of cematary, cramatory or othar place): Salisbury Crematory

Data:

20c. Location - City or Town, Stata: Salisbury,Md.

21. Signeture of Funeral Service Licensee: Earl M Hanby

22. Nama and Address of Facility: ~~Stewart Funeral Home~~ Salisbury Stewart Funeral Home

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only one causa on aach lina.

Approximete Interval Batween Onsat and Death

Immediata Causa (Final diseasa or condition resulting in daath): a. Metastatic Liver CANCER

Dua to (or as a consequence of):

Sequantially list conditions, if any, leading to immadiate ceusa. Entar Underlying Cause (Disaasa or Injury that initiated avants rasulting in death) Last: b.

Dua to (or as a consequance of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to daath but not resulting in tha underlying causa givan in Part I.: HTN, ASCVD, COPD

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Were autopsy findings available prior to completion of causa of daath? N/A 1 [ ] Yes 2 [ ] No

25. Was cesa rafarred to medical exeminer? 1 [ ] Yas 2 [X] No

26. Piece of Deeth (Check only one): Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA Othar: 4 [ ] Nursing Homa 5 [X] Residance 6 [ ] Othar (Specify)

27. Manner of Death: 1 [X] Naturel 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding invastigation 6 [ ] Could not be detarmined

28a. Date of Injury (Month, Day Yaer):

28b. Tima of Injury:

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Dascribe how injury occurred:

28e. Placa of Injury - At homa, farm, streat, factory, office building, etc. (Specify):

28f. Location (Straat and Number or Rurel Routa Number, City or Town, Stata):

29a. Cartifiar (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, daath occurred at the time, date and place, and due to the causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and place, and dua to the causa(s) and mannar statad.

29b. Signeture and title of certifier: Mahesh Moondra MD

29c. License number: D32017

29d. Date signed (Month, Dey, Yaar): 1/5/01

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): MAHESH MOONDRA 106 MILARD ST SUITE B SALISBURY MD 21804

State Registrar

31. Data filed (Month, Dey, Yaar): JAN 08 2001

32. Registrar's Signature: Penny D. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

11 DQ

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01530

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LEROY THOMAS KING, SR.
2. Date of Death Month Day Year: JANUARY 11, 2001
3. Time of Death: 2:30 AM
4a. Facility Name *(If not institution, give street and number)*: CIVISTA MEDICAL CENTER
4b. City, Town, or Location of Death: LA PLATA
4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 217-30-0843
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 64 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: OCT. 25, 1936
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: CHARLES
10c. City, Town or Location: BRYANS ROAD
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2405 MARSHALL HALL ROAD
10f. Zip Code: 20616
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7TH GRADE — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: BRICK LAYER
16b. Kind of Business/Industry: CONSTRUCTION

17. Father's Name *(First, Middle, Last)*: RAYMOND J. KING, SR.
18. Mother's Name *(First, Middle, Maiden Surname)*: BLANCHE IOLA BLAND KING

19a. Informant's Name/Relationship *(Type, Print)*: DORIS MILSTEAD / DAUGHTER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5430 CHICAMUXEN ROAD, INDIAN HEAD, MARYLAND 20640

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: TRINITY MEMORIAL GARDENS — Date: 1/15/01
20c. Location - City or Town, State: WALDORF, MARYLAND

21. Signature of Funeral Service Licensee: Lydia C. Thornton Johnson — LYDIA C. THORNTON JOHNSON M00583
22. Name and Address of Facility: THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CAVERNOUS HEMANGIOMA OF THE LIVER — YEARS
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
PLEURAL EFFUSIONS
HYPOALBUMINEMIA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
28. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Joel Sewchand MD, P.C
29c. License number: D-29646
29d. Date signed *(Month, Day, Year)*: JANUARY 11, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOEL SEWCHAND, M.D. 118 LA GRANGE AVENUE, P.O. BOX 975, LA PLATA, MARYLAND 20646

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001
32. Registrar's Signature: Denise G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01531

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Martha B. Kurtz
2. Date of Death (Month, Day, Year): January 04 2001
3. Time of Death: 1123
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 018-20-5111
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02/20/1923
9. Birthplace (State or Foreign Country): Texas

Usual Residence of Decedent

10a. State: MD
10b. County: Worcester
10c. City, Town or Location: Snow Hill
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3841 Sirman Drive
10f. Zip Code: 21863
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Edmund Barnum
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Allen

19a. Informant's Name/Relationship (Type, Print): Rev. Robert Kurtz/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3841 Sirman Drive, Snow Hill, Md. 21863

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): All Hallows Episcopal Cem. | Date: 1/8/01
20c. Location - City or Town, State: Snow Hill, Md.

21. Signature of Funeral Service Licensee: James L. Hinman #00295
22. Name and Address of Facility: Hinman Funeral Home, 11673 Somerset Ave., Princess Anne, MD. 21853

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death):
a. Ventricular Asystole — Approximate Interval Between Onset and Death: min
Due to (or as a consequence of):
b. myocardial ischemia — hr
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Coronary Artery Disease — yr
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Joseph Raffetto, M.D.
29c. License number: 20441
29d. Date signed (Month, Day, Year): JANUARY 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Raffetto, M.D. 400 E Shore Dr. Salisbury, MD 21804

State Registrar

31. Date filed (Month, Day, Year): JAN 5 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Martha Kurtz

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01532

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Catherine Elizabeth Lewis
2. Date of Death (Month, Day, Year): Jan. 10, 2001
3. Time of Death: 3:00 pm
4a. Facility Name (If not institution, give street and number): 17485 Stella Maris Rd.
4b. City, Town, or Location of Death: Rock Point
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 214-72-4028
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 43 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): September 14, 1957
9. Birthplace (State or Foreign Country): DC Washington

Usual Residence of Decedent

10a. State: MD
10b. County: Charles
10c. City, Town or Location: Rock Point
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 17485 Stella Maris Road
10f. Zip Code: 20682
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Driver
16b. Kind of Business/Industry: Bus/Transportation

17. Father's Name (First, Middle, Last): Bernard J. Viering, Jr.
18. Mother's Name (First, Middle, Maiden Surname): Mary Catherine Conner

19a. Informant's Name/Relationship (Type, Print): Larry Lewis/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 393 Cobb Island, MD 20625

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Brinsfield-Echols FH
Date: 1/12/01
20c. Location - City or Town, State: Charlotte Hall, MD

21. Signature of Funeral Service Licensee: David C. Echols M00945
22. Name and Address of Facility: AREHART-ECHOLS FUNERAL HOME, P.A. P.O. BOX 567 LA PLATA, MD. 20646

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one causa on each line.

		Approximate Interval Between Onset and Death
Immediate Causa (Final disease or condition resulting in death) a.	Obstructive Pulmonary Desease	5 yrs
Due to (or as a consequence of): b.	Asthmatic Bronchitis	15 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Hyperventilation Syndrome	2 yrs
d.	Morbid Obesity	20 yrs

Part II. Other signifcant conditions contributing to death but not resulting in the underlying cause givan in Part I.: Respiratory failure, Congestive Heart Failure, Seizure disorder, Diabetes Mellitus, Obstructive Sleep Apnea

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Ware autopsy findings available prior to completion of causa of daath? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residance 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. 2☐ Medicet Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D0008370
29d. Date signed (Month, Day, Year): 1/11/2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): P.O. Box 1317, 118 LA GRANGE AVE., LA PLATA, MD 20646

State Registrar

31. Data filed (Month, Day, Year): JAN 12 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01533

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SHIRLEY M. LANDON

2. Date of Death (Month, Day, Year): January 11 2001

3. Time of Death: 1310

4a. Facility Name *(If not institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 216-74-4237

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: February 6, 1933

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Somerset

10c. City, Town or Location: Crisfield

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 26581 Mariners Road

10f. Zip Code: 21817

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 0 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: None

16b. Kind of Business/Industry: None

17. Father's Name *(First, Middle, Last)*: Willard E. Landon

18. Mother's Name *(First, Middle, Maiden Surname)*: Alvenia Wilson

19a. Informant's Name/Relationship *(Type, Print)*: Willard E. Landon, Jr. (Brother)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 208 S. Somerset Avenue - Crisfield, MD 21817

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Sunnyridge Memorial Park

Date: 1/15/01

20c. Location - City or Town, State: Crisfield, MD

21. Signature of Funeral Service Licensee: Mary Beth Bradshaw-Pruitt

Mary Beth Bradshaw-Pruitt

22. Name and Address of Facility: Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis — 72hrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Urinary Tract Infection

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robt A. Coker

29c. License number: H00 56197

29d. Date signed *(Month, Day, Year)*: 1/11/01

30. Name and address of person who completed cause of death (item 23a) (Type, Print): Robert A. Coker, M.D. 100 E. Carroll St Salisbury MD 21801

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

216-74-4237

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Shirley Landon

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01534

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mildred Elizabeth McGrew

2. Date of Death (Month, Day, Year): Jan. 05, 2001

3. Time of Death: 8:03 AM

4a. Facility Name (If not institution, give street and number): Carroll County General Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 219-03-6256

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 07, 1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 611 David Ave.

10f. Zip Code: 21157

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Bieck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Harvey Lewis Miller

18. Mother's Name (First, Middle, Maiden Surname): Bessie Elizabeth Graf

19a. Informant's Name/Reletionship (Type, Print): Jeanne McGrew/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 611David Ave. Westminster, MD 21157

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Immanuel Lutheran Cem. | Date: 01/07/2001

20c. Location - City or Town, State: Manchester, Maryland

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: Pritts Funeral Home & Chapel, P.A. 412 Washington Rd. Westminster, MD 21157

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death) a.	Intracerebral Hemorrhage	72 hours
Due to (or as a consequence of):	ASCVD	25 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last b.		
Due to (or as a consequence of):	HTN	40 yrs
c.	COPD	25 yrs.
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D5072

29d. Date signed (Month, Day, Year): 1/5/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Shawn Taylor - Hoffman, Carroll County General Hospital, Westminster, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 08 2001

32. Registrar's Signature: Denise G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

MCGREW MILDRED

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 18 per F.D. 01/09/2001, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01535

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nancy Myles
2. Date of Death: Month: January Day: 7 Year: 2001
3. Time of Death: 10:30 am
4a. Facility Name (If not institution, give street and number): Fairhaven Nursing Center
4b. City, Town, or Location of Death: Sykesville
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 080-30-9329
6. Sex: 1☐ M 2☒ F
7. Age (in yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 19 1910
9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: Md
10b. County: Carroll
10c. City, Town or Location: Sykesville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7200 Third Avenue
10f. Zip Code: 21784
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker
16b. Kind of Business/Industry: domestic

17. Father's Name (First, Middle, Last): John Roeser
18. Mother's Name (First, Middle, Maiden Surname): ~~Ann Roeser~~ Anne Snyder

19a. Informant's Name/Relationship (Type, Print): John Myles Jr. (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 557 North St., White Plains, NY 10605

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): All County Cremation Date: 1-9-01
20c. Location - City or Town, State: Sykesville, Md

21. Signature of Funeral Service Licensee: ▶ Brian A Haight
22. Name and Address of Facility: Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Alzheimers disease	14 yrs
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D34849
29d. Date signed (Month, Day, Year): January 7, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Tan, MD 1645 Liberty Road Eldersburg MD 21784

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

Nancy Myles

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01536

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELLA FRANCIS MARTIN

2. Date of Death (Month, Day, Year): JAN. 7, 2001

3. Time of Death: 9:20 AM

4a. Facility Name (If not institution, give street and number): GENESIS ELDERCARE

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 217-20-6402

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 3/19/1906

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD. | 10b. County: CITY | 10c. City, Town or Location: BALTIMORE | 10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 131 NORTH HIGHLAND AVE. | 10f. Zip Code: 21224 | 10g. Citizen of Whet Country?: USA.

11. Marital Stetus: 1☐ Nevar Marriad 2☐ Merried 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Datas:

13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 9 | College (1-4or 5+):

16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired): SECRETARY

16b. Kind of Business/Industry: INSURANCE

17. Fathar's Nema (First, Middle, Last): GEORGE F. MODINGER

18. Mother's Name (First, Middle, Maiden Surname): CARLEY RAU

19a. Informent's Neme/Reletionship (Type, Print): PATRICIA REISMAN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19 FAIRGROUND AVE., TANEYTOWN, MD. 21787

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): WOODLAWN CEMETERY | Dete: 1/10/01

20c. Location - City or Town, State: WOODLAWN, MD.

21. Signeture of Funeral Service Licensee: Thom Fik

22. Name end Address of Facility: FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that causad tha death. Do not antar tha mode of dying, such as cardiac or raspiretory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onsat end Death

Immediete Ceuse (Finel disease or condition resulting in deeth): a. Arteriosclerosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in death) Last:

b.

Due to (or as e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopay findings available prior to completion of ceusa of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medicel exeminar? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, and dua to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, dete end piece, and due to the ceuse(s) and menner steted.

29b. Signeture end title of certifier: Jerome H. Ginsberg, M.D.

29c. Licansa number: D0020964

29d. Date signed (Month, Day, Year): 01-08-01

30. Neme end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print): Jerome H. Ginsberg, M.D. 8630 Liberty Plaza Mall Randallstown, MD 21133

State Registrar

31. Dete filed (Month, Day, Year): JAN 10 2001

32. Registrar's Signatura: Denise G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01537

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): AUDREY JENNY OLSEN
2. Date of Death (Month, Day, Year): January 2, 2001
3. Time of Death: 7:30 AM
4a. Facility Name (If not institution, give street and number): CROFTON CONVALESCENT CENTER
4b. City, Town, or Location of Death: CROFTON
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 091-22-3047
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): December 16, 1928
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Crofton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2131 Davidsonville Road
10f. Zip Code: 21114
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highest greda completad)
Elementary/Secondary (0-12): 12
College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired): Secretary
16b. Kind of Business/Industry: Public Library

17. Father's Nama (First, Middle, Last): Donald Laidlaw Hall
18. Mother's Name (First, Middle, Meiden Surname): Alma Syvertsen

19a. Informant's Name/Relationship (Type, Print): Holly Crouse/Daughter
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1032 May Court, Gambrills, MD 21054

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Woodland Cemetery
Date: 5/1/01
20c. Location - City or Town, State: Delhi, NY

21. Signature of Funeral Service Licensee: David A. Thompson M01051
22. Nama and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on each line.

Approximate Interval Between Onset and Death

Immediate Causa (Final disease or condition resulting in death)
a. END STAGE ALZHEIMERS DISEASE — YEARS
Due to (or as a consequence of):

Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Diseasa or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Dua to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 8☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, atc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signatura and titla of certifier: Paul J Rhodes MD
29c. License number: D22028
29d. Data signed (Month, Dey, Year): 1/2/01

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): PAUL J. RHODES, MD 1667 CROFTON CENTRE, CROFTON, MD 21114

State Registrar

31. Date filed (Month, Dey, Yeer): JAN 08 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01538

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Monroe Howard Pickett
2. Date of Death Month / Day / Year: January 1, 2001
3. Time of Death: 1:00 PM
4a. Facility Name *(If not institution, give street and number)*: Carroll County General Hospital
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 214-28-0382
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 86 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: November 7, 1914
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll County
10c. City, Town or Location: New Windsor
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3730 Hooper Rd.
10f. Zip Code: 21776
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6th grade; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Farmer
16b. Kind of Business/Industry: Agriculture

17. Father's Name *(First, Middle, Last)*: Howard Pickett
18. Mother's Name *(First, Middle, Maiden Surname)*: Emma Williams

19a. Informant's Name/Relationship *(Type, Print)*: Marguerite Pickett (Wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3730 Hooper Rd. New Windsor, MD 21776

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Taylorsville Cemetery
Date: Jan 5, 2001
20c. Location - City or Town, State: Taylorsville, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Burrier-Queen Funeral Directors, PA
1212 West Old Liberty Rd. Winfield, MD 21784

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS — 10 days
Due to (or as a consequence of): SEPSIS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. PROSTATE CANCER — 6 years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CORONARY ARTERY DISEASE; CEREBROVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Thomas K. Galvin III
29c. License number: D31660
29d. Date signed *(Month, Day, Year)*: 01/01/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THOMAS GALVIN MD 291 STONER AVE WESTMINSTER, MD 21157

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01539

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas Jethro Pinder

2. Date of Death (Month, Day, Year): JAN. 07 2001

3. Time of Death: 1400hrs

4a. Facility Name (If not institution, give street and number): Dorchester General

4b. City, Town, or Location of Death: Cambridge

4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 214-36 6074

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 103 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jul. 26, 1897

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Dorchester

10c. City, Town or Location: Hurlock

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 4222 East N.Mkt.-Hurlock Rd.

10f. Zip Code: 21643

10g. Citizen of What Country? United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Grain & Produce Farmer

16b. Kind of Business/Industry: Agriculture

17. Father's Name (First, Middle, Last): Charles Pinder

18. Mother's Name (First, Middle, Maiden Surname): Sarah Pinder

19a. Informant's Name/Relationship (Type, Print): Laura Mae Pinder/Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 206, Hurlock, MD 21643

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, cremetory or other place): Fork Neck Cemetery

Date: 01/11/01

20c. Location - City or Town, State: Linkwood, MD

21. Signature of Funeral Service Licensee: Michael F. Eskow

22. Name and Address of Facility: Framptom-Hawkins-Eskow Funeral Home, PA PO Box 43, Federalsburg, MD 21632

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one ceusa on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in death)

a. Cardiac Arrhythmia — 4 min

Due to (or es a consequence of):

Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Last

b. ____

Due to (or es e consequence of):

c. ____

Due to (or es e consequence of):

d. ____

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of causa of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yas 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D76358

29d. Date signed (Month, Day, Year): JAN 08, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Fallin 302 Collins, Hurlock Md 21643

State Registrar

31. Date filed (Month, Day, Year): JAN 9 2001

32. Registrar's Signature: Geneva D. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01540

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frances Ellen Pitts
2. Date of Death (Month, Day, Year): Jan. 8, 2001
3. Time of Death: 9:55PM
4a. Facility Name (If not institution, give street and number): Shore Nursing & Rehabilitation Center
4b. City, Town, or Location of Death: Denton
4c. County of Death: Caroline

Funeral Director

5. Social Security Number: 190-16-9984
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov.15,1913
9. Birthplace (State or Foreign Country): Pa.

Usual Residence of Decedent

10a. State: Md.
10b. County: Queen Anne
10c. City, Town or Location: Grasonville
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 16 Grasonville Terrace
10f. Zip Code: 21638
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Line Worker
16b. Kind of Business/Industry: Food Processing

17. Father's Name (First, Middle, Last): (Unknown) McKnight
18. Mother's Name (First, Middle, Maiden Surname): Margaret Robinson

19a. Informant's Name/Relationship (Type, Print): Beatrice E. Palone/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 23 Osprey Ct., Montross, Va. 22520

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Capitol Crematory — Date: 1/9/01
20c. Location - City or Town, State: Dover, De.

21. Signature of Funeral Service Licensee: Randolph P. Moore
22. Name and Address of Facility: Moore Funeral Home, P.A. 12 S. Second St., Denton, Md. 21629

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Bacterial Sepsis — 1wk
Due to (or as a consequence of): b. Sacral Decubitus Ulcer — 1Month
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes; Dementia

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)
27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D32036
29d. Date signed (Month, Day, Year): 1/9/2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Gary T. Sprague 2108 DiDonato Drive Chester, MD 21619

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01541

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Martha Willard Riner
2. Date of Death Month Day Year: Jan. 09, 2001
3. Time of Death: 9:22PM
4a. Facility Name *(If not institution, give street and number)*: Civista Medical Center
4b. City, Town, or Location of Death: La Plata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 236-38-5734
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 14,1916
9. Birthplace *(State or Foreign Country)*: PA

Usual Residence of Decedent

10a. State: MD.
10b. County: Charles
10c. City, Town or Location: La Plata
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: One Magnolia Drive
10f. Zip Code: 20646
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Weaver
16b. Kind of Business/Industry: Silk Mill
17. Father's Name *(First, Middle, Last)*: William Henry Roach
18. Mother's Name *(First, Middle, Maiden Surname)*: Unknown
19a. Informant's Name/Relationship *(Type, Print)*: Martha Ashton-Croson/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7457 Howard Dr. Port tobacco,MD. 20677
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rosedale Cemetery
Date: 1/13/01
20c. Location - City or Town, State: Martinsburg,WV
21. Signature of Funeral Service Licensee: David C. Echols M00945
22. Name and Address of Facility: AREHART-ECHOLS FUNERAL HOME,P.A. P.O. BOX 567 LA PLATA,MD. 20646

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the death. Do not enter ihe mode of dying, such es cerdiac or respiretory arrest, shock, or heart failure. List *only one* cause on each line.

Approximate Intervel Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death): a. Aspiration Pneumonia

Due to (or as a consequence of): Renal Failure

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but noi resulting in the underlying cause given in Part I.

23b. Did tobacco use contributs to the causs of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier:
29c. License number: D-45737
29d. Date signed *(Month, Day, Year)*: 1/9/01

30. Name and address of person who compieied ceuse of deeth (Item 23a) (Type, Print): Nirmaladevi Gurusamy,MD 6 Post Office Road, Suite 103, Waldorf,Maryland 20602

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 12 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Martha Riner
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01542

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDNA MAE REYNOLDS
2. Date of Death (Month, Day, Year): January 9, 2001
3. Time of Death: 8:11 PM
4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 577-24-6926
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 5, 1922
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Waldorf
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 70 Village Street
10f. Zip Code: 20604
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Budget Analyst
16b. Kind of Business/Industry: US Government

17. Father's Name (First, Middle, Last): Ira Fletcher Spradlin
18. Mother's Name (First, Middle, Maiden Surname): Edna Earl Mitchell

19a. Informant's Name/Relationship (Type, Print): John H. Reynolds - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 27783 Baptist Church Rd., Mechanicsville, MD 20659

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Resurrection Cenetery
Date: 1-13-01
20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: Mark A. Bremawn M00053
22. Name and Address of Facility: Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20604-0156

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pulmonary Edema — Hrs
Due to (or as a consequence of):
b. Myocardial Failure — Hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Arteriosclerotic Cardiovascular Heart Disease — Yrs
Due to (or as a consequence of):
d. Chronic Obstructive Pulmonary Disease — Yrs

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Thomas L. Fuldauer DO
29c. License number: D001929
29d. Date signed (Month, Day, Year): Jan 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): T. L. Fuldauer MD Waldorf MD 20601

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001
32. Registrar's Signature: G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1/9/2001 @ 8:11 pm

Reynolds, Edna

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01543

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Shirley Dorothy Rupert

2. Date of Death Month Day Year: January 6, 2001

3. Time of Death: 2:45AM

4a. Facility Name *(If not institution, give street and number)*: 2021 3D Rudy Serra Drive

4b. City, Town, or Location of Death: Eldersburg

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 496 - 38 - 2811

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug 14, 1939

9. Birthplace *(State or Foreign Country)*: Missouri

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Eldersburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2021 3D Rudy Serra Drive

10f. Zip Code: 21784

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Frank Brown

18. Mother's Name *(First, Middle, Maiden Surname)*: Marcella Rohlfing

19a. Informant's Name/Relationship *(Type, Print)*: Marion J. Rupert/Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2021 3D Rudy Serra Drive Eldersburg, Maryland 21784

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Carroll Cremation, Inc.

Date: 1/9/2001

20c. Location - City or Town, State: Hampstead Maryland

21. Signature of Funeral Service Licensee: Jeffry N. Zumbrun

22. Name and Address of Facility: Jeffrey N. Zumbrun Funeral Home & Monument Co. 6028 Sykesville Road Eldersburg, Maryland 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SMALL CELL LUNG CA — 1 1/2yr

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Flavio Kruter MD

29c. License number: D35398

29d. Date signed *(Month, Day, Year)*: 1-8-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Flavio Kruter 555 South Center Street Westminster, Maryland 21157

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 08 2001

32. Registrar's Signature: Deanna G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01544

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ZELDER MAE THOMAS SWAILES
2. Date of Death: Month Jan. Day 11, Year 2001
3. Time of Death: 10:55am
4a. Facility Name (If not institution, give street and number): Civista Medical Center
4b. City, Town, or Location of Death: LaPlata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 220-28-6620
6. Sex: 1☐ M 2☒ F
7. Age (in yrs. last birthday): 76 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MARCH 30, 1924
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: CHARLES
10c. City, Town or Location: INDIAN HEAD
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6 JAMESON COURT
10f. Zip Code: 20640
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PRESSOR
16b. Kind of Business/Industry: DRYCLEANER

17. Father's Name (First, Middle, Last): SAMUEL L. THOMAS
18. Mother's Name (First, Middle, Maiden Surname): SARAH MARIE POSEY THOMAS

19a. Informant's Name/Relationship (Type, Print): VANESSA JOHNSON/DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1100 ALHAMBRA AVE., ACCOKEEK, MD 20607

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): PLEASANT GROVE BAPTIST CH
Date: 01/16/01
20c. Location - City or Town, State: MARBURY, MD

21. Signature of Funeral Service Licensee: Lydia C. Thornton Johnson 00583
LYDIA C. THORNTON JOHNSON
22. Name and Address of Facility: THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON RD, INDIAN HEAD, MD 20640

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ANOXIC ENCEPHALOPATHY 3-4 day
Due to (or as a consequence of):
b. CARDIAC ARREST
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. VENTRICULAR FIBRILLATION
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CORONARY ARTERY DISEASE
CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury — M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D-44436
29d. Date signed (Month, Day, Year): JAN 11 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Ashvinkumar J. Patel, M.D. 102 Paul Mellon Dr. Waldorf, MD 20602

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001
32. Registrar's Signature: Geneva D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Zelda M. Swailes

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01545

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Clyde Spangler, SR.

2. Date of Death: Month JAN Day 06 Year 2001

3. Time of Death: 255 PM

4a. Facility Name (If not institution, give street and number): Levindale Geriatric Center

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 401-14-0693

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 87 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): Jan. 04 1914

9. Birthplace (State or Foreign Country): Kentucky

Usual Residence of Decedent

10a. State: MD

10b. County: CARROLL

10c. City, Town or Location: Eldersburg

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 6309 Wild Lake Drive

10f. Zip Code: 21784

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - Americen Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): 12

College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): engineer

16b. Kind of Business/Industry: Automotive

17. Father's Name (First, Middle, Last): Palmer M. Spangler

18. Mother's Name (First, Middle, Maiden Surname): Lillar Stalland

19a. Informant's Name/Relationship (Type, Print): Laura Loyd / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6309 Wild Lake Drive Eldersburg MD 21784

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Mem. Park

Date: 1/10/2001

20c. Location - City or Town, State: Elkridge, Md.

21. Signature of Funeral Service Licensee: J. Zumbrun

22. Name and Address of Facility: J. N. Zumbrun Eh. & Mon. Co. 6028 Sykesville Road Eldersburg MD 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Recurrent Aspiration Pneumonia — 1 day

Due to (or as a consequence of):

b. Dementia — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medicet examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Debra Wertheimer MD

29c. License number: D23767

29d. Date signed (Month, Day, Year): January 8 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Debra Wertheimer MD 2434 W. Belvedere Ave, Balto, MD 21215

State Registrar

31. Date filed (Month, Day, Year): JAN 08 2001

32. Registrar's Signeture: Penny G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Spangler, William

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01546

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Clyde Specht, Jr.

2. Date of Death (Month, Day, Year): January 5, 2001

3. Time of Death: 7:53 pm

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick County

Funeral Director

5. Social Security Number: 214-10-3735

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 10, 1912

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll County

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 314 Avalon Lane

10f. Zip Code: 21158

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1944-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): presser

16b. Kind of Business/Industry: garment manufacture

17. Father's Name (First, Middle, Last): William C. Specht, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Mary Isabelle Linton

19a. Informant's Name/Relationship (Type, Print): Carolyn Abrecht / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 314 Avalon Lane Westminster, Maryland 21158

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Church of Brethren Cem.

Date: Jan 9 2001

20c. Location - City or Town, State: Rocky Ridge, MD

21. Signature of Funeral Service Licensee: Alan C. Purvis M01072

22. Name and Address of Facility: Skiles Funeral Home 136 East Baltimore Street Taneytown, MD 21787

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. MASSIVE HEMORRHAGE CEREBELLUM — 3 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: George I. Smith, M.D. VPMA

29c. License number: D10587

29d. Date signed (Month, Day, Year): 1/8/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GEORGE I. SMITH M.D. VICE-PRES MED AFFAIRS FREDERICK MEM. HOSP., 400 WEST 7TH STREET FREDERICK, MD 21701

State Registrar

31. Date filed (Month, Day, Year): JAN 08 2001

32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

JAN 06 2001

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01547

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LAVERNE E. SMITH
2. Date of Death Month: January Day: 5th Year: 2001
3. Time of Death: 7:10P
4a. Facility Name (If not institution, give street and number): Carroll County General Hospital
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 217-12-2133
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 7, 1920
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll County
10c. City, Town or Location: Taneytown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3080 Roop Road
10f. Zip Code: 21787
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942-1963
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): zoning/planning administrator
16b. Kind of Business/Industry: city administration

17. Father's Name (First, Middle, Last): Calvin Smith
18. Mother's Name (First, Middle, Maiden Surname): Alice Null

19a. Informant's Name/Relationship (Type, Print): Lois Smith / wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3080 Roop Road Taneytown, Maryland 21787

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Pleasant Cemetery
Date: Jan. 9 2001
20c. Location - City or Town, State: Taneytown, Maryland

21. Signature of Funeral Service Licensee: Alan C. Kerns M01072
22. Name and Address of Facility: Skiles Funeral Home 136 East Baltimore Street Taneytown, MD 21787

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia
Due to (or as a consequence of): b. Lung cancer
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D48006
29d. Date signed (Month, Day, Year): January 5th, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KOFI BONITEY, CARROLL COUNTY GENERAL HOSPITAL, 200 Memorial Avenue, Westminster, MD 21157

State Registrar

31. Date filed (Month, Day, Year): JAN 08 2001
32. Registrar's Signature: Jeanne G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Laverne E. Smith

Patient Known as Christine Sommersdorf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01548

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CHRISTINE ANNA SOMMERSDORF
2. Date of Death — Month: January Day: 6 Year: 2001
3. Time of Death: 2225
4a. Facility Name *(If not institution, give street and number)*: Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-42-2885
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 56 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 19, 1944
9. Birthplace *(State or Foreign Country)*: Germany

To Be Completed by Funeral Director

Usual Residence of Decedent

10e. State: Maryland
10b. County: Carroll County
10c. City, Town or Location: Taneytown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3725 Old Taneytown Road
10f. Zip Code: 21787
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: cashier
16b. Kind of Business/Industry: retail store

17. Father's Name *(First, Middle, Last)*: Wladyslaw Klaput
18. Mother's Name *(First, Middle, Maiden Surname)*: Maria Pietczak

19e. Informant's Name/Relationship *(Type, Print)*: Mark G. Sommersdorf / husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3725 Old Taneytown Road Taneytown, MD 21787

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Smithsburg Crematorium
Date: Jan. 7 2001
20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: Alan C. Rivis M01072
22. Name and Address of Facility: Skiles Funeral Home 136 East Baltimore Street Taneytown, MD 21787

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Adenocarcinoma of the lung — 3 months
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Brenda MD
29c. License number: RES 000
29d. Date signed *(Month, Day, Year)*: January 6, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Brenda M. Acosta, MD 2401 W. Belvedere Ave., Baltimore, MD 21215 Sinai Hospital of Baltimore

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 08 2001
32. Registrar's Signature: Geneva G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01549

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jacqueline Schleicher
2. Date of Death Month Day Year: January 11 2001
3. Time of Death: 8:10 PM
4a. Facility Name *(If not institution, give street and number)*: Caroline Nursing Home
4b. City, Town, or Location of Death: Denton
4c. County of Death: Caroline

Funeral Director

5. Social Security Number: 131-26-5566
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 66 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: August 28, 1934
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Caroline
10c. City, Town or Location: Denton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 908 B Gay Street
10f. Zip Code: 21629
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Accounting Clerk
16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: Robert Ribenbark
18. Mother's Name *(First, Middle, Maiden Surname)*: Myrtle Hansen

19a. Informant's Name/Relationship *(Type, Print)*: Katherine Hansen Oderwald
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2956 Cambridge Road Wantagh, New York 11793

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Cremation
Date: 1/13/2001
20c. Location - City or Town, State: Chester, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Fleegle-Helfenbein Funeral Home, PA
PO Box 160 Greensboro, Maryland 21639

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — Days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Severe Chronic Obstructive Pulmonary Disease, Lung Cancer

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ James Sides MD
29c. License number: D31376
29d. Date signed *(Month, Day, Year)*: 1-12-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James Sides 920 Market St Denton MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Obstructive Pulmonary
Cancer

MD
Mark

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01550

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GLADYS OLIVE TILGHMAN

2. Date of Death: Month January Day 3 Year 2001

3. Time of Death: 0650

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 216-16-7199

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): December 15, 1924

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 6483 Ford Circle

10f. Zip Code: 21801

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 7; College (1-4or 5+): –

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Beautician

16b. Kind of Business/Industry: Cosmotology

17. Father's Name (First, Middle, Last): Dorsey Gravenor

18. Mother's Name (First, Middle, Maiden Surname): Zella Goode

19a. Informant's Name/Relationship (Type, Print): Johnny Layton/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6475 Ford Circle, Salisbury, MD 21801

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Springhill Memory Gardens

Date: 1/5/01

20c. Location - City or Town, State: Hebron, MD

21. Signature of Funeral Service Licensee: John M. Holloway

22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac arrythmia — days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rene Desmarais

29c. License number: D38353

29d. Date signed (Month, Day, Year): JANUARY 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rene Desmarais, M.D. 400 E. Shore Dr. Salisbury, MD 21804

State Registrar

31. Date filed (Month, Day, Year): JAN 08 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Gladys Tilghman

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3 10 DQ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01551

Mabel Tomlinson

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: MABEL MURDOCK TOMLINSON
2. Dete of Deeth Month Dey Yeer: 01 - 05 - 2001
3. Time of Deeth: 10 40 Am
4e. Facility Neme *(If not institution, give street end number)*: HARTLEY HALL
4b. City, Town, or Location of Deeth: POCOMOKE CITY
4c. County of Deeth: WORCESTER

Funeral Director

5. Sociel Security Number: 209-26-7958 A
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. lest birthday)*: 92 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: July 27, 1908
9. Birthplece *(Stete or Foreign Country)*: Ireland

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Worcester
10c. City, Town or Location: Pocomoke City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 1006 Market Street
10f. Zip Code: 21851
10g. Citizen of Whet Country?: USA

11. Merital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12; College (1-4or 5+): -
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Machine Operator
16b. Kind of Business/Industry: Blue Print

17. Fether's Neme *(First, Middle, Last)*: Daniel M. Murdock
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Annie Toezer Lovelace

19a. Informent's Name/Reletionship *(Type, Print)*: Peter E. Tomlinson/Son
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 3394 Blackbeard Rd., Greenbackville, VA 23356

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Plece of Disposition *(Neme of cemetery, cremetory or other piece)*: Salisbury Crematory
Dete: 1/6/01
20c. Location - City or Town, Stete: Salisbury, MD

21. Signeture of Funeral Service Licensee: David A. Thompson
22. Neme and Address of Fecility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet cause the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Finel disease or condition resulting in deeth)
e. Hypoxic Encephalopathy
Due to (or es a consequence of):
b. Dementia

Sequentieily list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest
Due to (or es a consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Lung Disease; Anemia; Osteoporosis; Osteoarthritis; S/P Myocardial Infarction; Pacemaker

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☑ No

25. Was case reported to medical examiner? 1☐ Yes 2☑ No
26. Plece of Deeth *(Check only one)*: Hospital: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28e. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete and plece, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Sarad
29c. License number: D 54422
29d. Dete signed *(Month, Dey, Yeer)*: 1/5/01

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): SARAD RAJ BARAL; 1604-Market St.; Pocomoke, MD 21851

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DQ 10

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 08 2001
32. Registrer's Signeture: Penny G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01552

JAMES WATSON

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES ERNEST WATSON
2. Date of Death (Month, Day, Year): JANUARY 11 2001
3. Time of Death: 4:35 AM
4a. Facility Name (If not institution, give street and number): CIVISTA MEDICAL CENTER
4b. City, Town, or Location of Death: LAPLATA
4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 218-24-6935
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 73 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): November 2,1927
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Charles
10c. City, Town or Location: Bel Alton
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street and Number: 8620 Fairgrounds Road
10f. Zip Code: 20611
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Heavy Equipment Operator
16b. Kind of Business/Industry: Construstion

17. Father's Name (First, Middle, Last): Guy Watson
18. Mother's Name (First, Middle, Maiden Surname): Anita Watson

19a. Informant's Name/Relationship (Type, Print): Ruth Watson/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 1288 La Plata,MD. 20646

20a. Method of Disposition: X 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sacred Heart Cemetery
Date: 1/16/01
20c. Location - City or Town, State: La Plata,Maryland

21. Signature of Funeral Service Licensee: David C. Echols M00945
22. Name and Address of Facility: AREHART-ECHOLS FUNERAL HOME,P.A. P.O. BOX 567 LA PLATA,MD. 20646

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ANOXIC ENCEPHALOPATHY 1 day

Due to (or as a consequence of):
b. RESPIRATORY FAILURE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) TRANSITION CARE UNIT

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred

26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D-44436
29d. Date signed (Month, Day, Year): JAN 11 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ashvinkumar J. Patel,MD. 102 Paul Mellon Drive, Ste. 102, Waldorf,Maryland 20602

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001
32. Registrar's Signature: [signature] G. Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01553

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Elizabeth Wetzel
2. Date of Death Month / Day / Year: January 8 2001
3. Time of Death: 6:30 AM
4a. Facility Name *(If not institution, give street and number)*: Avalon Manor Nursing Home
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 215-09-1386
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 1, 1918
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Frederick
10c. City, Town or Location: Keymar
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 12205 Warner Rd.
10f. Zip Code: 21757
10g. Citizen of What Country?: U.S.A.

11. Meritet Status: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 / College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: homemaker
16b. Kind of Business/Industry: own home

17. Father's Name *(First, Middle, Last)*: Floyd Hamilton Smith
18. Mother's Name *(First, Middle, Maiden Surname)*: Elsie Hattie Rappuhn

19a. Informant's Neme/Reletionship *(Type, Print)*: Betty R. Ridgley - daughter
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6602 Cherry Hill Dr., Frederick, MD 21702

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Resthaven Mem. Gardens
Dete: Jan.10 2001
20c. Location - City or Town, State: Frederick, MD
21. Signature of Funeral Service Licensee: Catherine O. Hartzler
22. Neme end Address of Fecility: Hartzler Funeral Home 11802 Liberty Rd., Libertytown, MD

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart feilure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Final diseesa or condition resulting in death): a. Pneumonia — 3-4 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Arteriosclerotic Cardiovascular Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Nature 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) and menner es stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted.

29b. Signeture and title of certifier: MD
29c. License number: D18019
29d. Date signed *(Month, Day, Year)*: Jan 8, 2001

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print): DR. VASANT DATTA 334 MILL STREET HAGERSTOWN, MD 21740

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 09 2001
32. Registrar's Signeture: Geneva G Sparks

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ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Mary E. Wetzel 1-8-01 6:30AM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01554

Adkinson, Calvin

Physician (Medical Examiner)

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Calvin	Coolridge	Adkinson	January	19	2001	1:30 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Agnes Hospital	Baltimore	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
248-40-8208	1☒ M 2☐ F	73 Yrs.			07 02 27	S.C.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
820 Caton Ave #9D	21229	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
6th grade	na	Construction Worker	Whiting & Turner Co.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Adkinson	Eliza Kelly

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Margaret Adkinson-Wife	820 Caton Ave #9D, Baltimore Md 21229

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	King Memorial Park	1/25/01	Randallstown, Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
John B. Johnson Jr.	March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. End Stage cardiomyopathy	days
Due to (or as a consequence of):	b. Congestive heart failure	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

Hypertension

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☑ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Hwan Young Yoo, MD	D0053514	January, 19 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hwan Y. Yoo, MD. St. Agnes Hospital, Baltimore, MD 21229

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 24 2001	Anna G. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01555

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary E. Burns
2. Date of Death (Month, Day, Year): JAN. 23 2001
3. Time of Death: 12:59 AM
4a. Facility Name (If not institution, give street and number): St. Agnes Nursing & Rehab Center
4b. City, Town, or Location of Death: Ellicott City MD
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 215-03-5910
6. Sex: 1 ☐ M 2 ☑ F
7. Age (In yrs. last birthday): 93 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 09/22/1908
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 3000 North Ridge Road
10f. Zip Code: 21043
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accountant
16b. Kind of Business/Industry: Financial

17. Father's Name (First, Middle, Last): John W. Amoss
18. Mother's Name (First, Middle, Maiden Surname): Laura Evans

19a. Informant's Name/Relationship (Type, Print): Barbara Rush / daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1065 Elm Road, Arbutus, Maryland 21227

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery
Date: 1/25/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Juanita R Thomas
22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PNEUMONIA	1 WEEK
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James P. Richardson MD
29c. License number: D 27394
29d. Date signed (Month, Day, Year): 1/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMES P. RICHARDSON M.D. 700 GEORGE ROAD, CATONSVILLE, MD 21228

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01556

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marie Josephine Barany
2. Date of Death (Month, Day, Year): January 23, 2001
3. Time of Death: 1:20 PM

4a. Facility Name (If not institution, give street and number): 1520 Woodcliff Avenue
4b. City, Town, or Location of Death: Woodlawn
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-22-5875
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 21, 1920
9. Birthplace (State or Foreign Country): PA.

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Woodlawn
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1520 Woodcliff Avenue
10f. Zip Code: 21228
10g. Citizen of What Country?: USA

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 8+ College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): EDucator
16b. Kind of Business/Industry: School System

17. Father's Name (First, Middle, Last): Anthony Sansone
18. Mother's Neme (First, Middle, Maiden Surname): Mary Sansone

19a. Informant's Name/Relationship (Type, Print): Cordia Krastel- niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 140 Holly Circle, Baltimore, Maryland 21221

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Cross Cemetery
Date: 01/26/01
20c. Location - City or Town, Stete: Gken Burnie, Md.

21. Signature of Funeral Service Licensee: Kim Schlanger 01/25/
22. Name and Address of Facility: Witzke Funeral Home, Inc. 1630 Edmondson Ave., Catonsville, Maryland 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARDIAC ARRYTHMIA — 8 MO.

Due to (or as a consequence of):
b. HYPERTENSIVE CARDEOVASCULAR DISEASE — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. ALLERGIC AIRWAY DISEASE — 11

Due to (or es e consequence of):
d. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — 11

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
HYPOTHYROIDISM

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted.

29b. Signeture and title of certifier: John A Nesbitt III MD
29c. License number: D0014623
29d. Date signed (Month, Day, Year): 1/24/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN A. NESBITT III MD 5351 200 E. 33RD ST. BALT., MD. 21218

State Registrar

31. Dete filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: Linda G. Sparks

FEB 25 2000

ORIGINAL

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Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Marie Josephine Barany
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ADH
SHEILA BONDS
01-0318-510

ADMEND ITEM: #18 PER F.H. G794 4-25-01 WR.

AMEND ITEM 23a & 27 per ME G793 032801 SS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01557

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Sheila Watson Bonds	JANUARY 19, 2001	1426 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3905 MARX AVENUE	BALTIMORE CITY	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-70-1139	1☐ M 2☒ F	44 Yrs.			July 16, 1956	Germany

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3905 Marx Avenue	21206	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Banking	Bank of America

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Herbert W. Watson Sr.	SUSIE M. BLANDING ~~Susie M. Blandon~~

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Susie M. Watson-Mother	727 Cator Ave. Balto. MD 21218

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Western Star Cemetery	01/26	Balto. MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Nutter Funeral Home Inc. 2501 Gwynns Falls Pkwy. Balto. MD 21216

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heert feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. CARDIAC ARRYTHMIA DUE TO MYOCARDIAL FIBROSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or es a consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown	1☑ Yes 2☐ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) AT SCENE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	OCME	JANUARY 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
H.S. Ryan M.D. A. Kobler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 24 2001	▶ [signature]

ORIGINAL

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ADH
CHARLES BRISIEL
01-0319-510
amend item 23a,27,28a,b,c,d,e,f per me G791 1/31/01 yf

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01558

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Albert Brisiel
2. Date of Death (Month, Day, Year): JANUARY 19, 2001
3. Time of Death: 2028 PM

4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-74-3619
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 45 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 12, 1955
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Brooklyn Park, MD
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 621 Wood Street
10f. Zip Code: 21225
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machine Operator
16b. Kind of Business/Industry: Manufacturing

17. Father's Name (First, Middle, Last): Howard F. Brisiel, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Eva C. Varina

19a. Informant's Name/Relationship (Type, Print): Eric S. Brisiel / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1435 Reynolds Street, Baltimore Maryland 21230

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Othar (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HOly Cross Cemetery
Date: January 26, 2001
20c. Location - City or Town, State: Baltimore Maryland

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.
22. Neme end Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximata Interval Batween Onset and Death

Immediate Causa (Final disease or condition resulting in death): a. NARCOTIC AND ALCOHOL INTOXICATION

Dua to (or as a consaquence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [✓] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was casa referred to medicat examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only ona)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA
Other: 4 [ ] Nursing Homa 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined

28a. Date of Injury (Month, Day Year): found 1/19/01
28b. Time of Injury: found 7:45 P M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: subject ingested drugs and alcohol
28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify): found at home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 621 Wood Street, Baltimore, Maryland

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: OCME
29d. Date signed (Month, Day, Year): JANUARY 20, 2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): P. Dayaalan P. Kokate 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0354-510
CJ
Lawrence Bolding, Jr.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01559

Physician /Medical Examiner

Funeral Director

1. Decedent's Name *(First, Middle, Last)*: Lawrence I. Bolding, Jr.

2. Date of Death — Month: January; Day: 22; Year: 2001

3. Time of Death: 06:56 A.M.

4a. Facility Name *(If not institution, give street and number)*: Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

5. Social Security Number: 214-50-6358

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 52 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Mar 10, 1948

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 1745 East North Avenue

10f. Zip Code: 21213

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer

16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: Lwarence I. Bolding, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Clara Lee Jeffries

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Gloria Bolding-Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1745 East North Avenue, Baltimore, MD 21213

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Voshell Mem. Park

Date: Jan 27 2001

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Calvin L. Williams

22. Name and Address of Facility: Smith & Williams Funeral Home, P.A. 2818 East Baltimore Street Baltimore, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cirhosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Chronic Alcoholism

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? partial 1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury: M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis J. Chutkow

29c. License number: O.C.M.E.

29d. Date signed *(Month, Day, Year)*: January 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chutkow 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001

32. Registrar's Signature: Benjamin D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

8-6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01560

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY J. BATTLE

2. Data of Death Month Day Yaar: JANUARY 23, 2001

3. Tima of Death: 7:25am

4a. Facility Nama *(If not institution, giva street and number)*: MARINER OF CATONSVILLE

4b. City, Town, or Location of Death: CATONSVILLE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-24-4570

6. Sax: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: FEB. 11, 1919

9. Birthplaca *(State or Foreign Country)*: SC

Usual Rasidance of Dacedant

10a. Stata: MD

10b. County: BALTIMORE

10c. City, Town or Location: CATONSVILLE

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 98 SMITHWOOD AVENUE

10f. Zip Code: 21228

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Nevar Marriad 2☐ Marriad 3☒ Widowad 4☐ Divorcad

12. Was Dacedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Dacedant of Hispanic Origin? (Specify Yas or No- if Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* AFRICAN AMERICAN

15. Dacadant's Education *(Specify only highast grada complatad)*: Elamantary/Sacondary (0-12): 10th; Collaga (1-4or 5+): NA

16a. Dacadant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: NURSE

16b. Kind of Busalnass/Industry: HEALTH CARE

17. Fathar's Nama *(First, Middla, Last)*: ELLIOTT JENKINS

18. Mothar's Nama *(First, Middla, Maidan Sumama)*: REBECCA JENKINS

19a. Informant's Nama/Ralationship *(Typa, Print)*: MICHAEL SEGANISH (GUARDIAN)

19b. Mailing Address *(Straat and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Cada)*: 606 BALTIMORE AVE SUITE 106 BALTIMORE, MD 21204

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of camatary, cramatory or othar placa)*: MT. ZION CEMETERY

Data: 1/26/01

20c. Location - City or Town, Stata: LANSDOWNE, MD

21. Signatura of Funaral Sarvica Licansaa: [signature]

22. Nama and Addrass of Facility: WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part I. Entar the disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or hart failura. List only ona causa on each lina.

Approximate Interval Batwaan Onsat and Death

Immadiata Causa (Final disaasa or condition rasulting in daath): a. ASCVD — Yrs.

Dua to (or as a consaquanca of): b. HTN — Yrs.

Saquantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiatad avants rasulting in daath) Last:

Due to (or as a consaquanca of): c.

Dua to (or as a consaquanca of): d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.: S/P CVA; IDDM

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Wara autopsy findings availabla prior to complation of cause of daath? 1☐ Yas 2☐ No

25. Was case rafarrad to madical examinar? 1☐ Yes 2☑ No

26. Placa of Daath *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☑ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Manner of Daath: 1☑ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not ba datarminad

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurrad

28e. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Straat and Numbar or Rural Routa Numbar, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☑ **Certifying Physician**: To tha bast of my knowladga, daath occurrad at the time, data and placa, and due to tha causa(s) and manner as stated. 2☐ **Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, death occurrad at the time, data and placa, and due to the causa(s) and mannar stated.

29b. Signatura and titla of cartifiar: [signature] M.D. Covering attending

29c. Licansa number: D36942

29d. Data signed *(Month, Day, Yaar)*: January 23, 2001

30. Nama and addrass of parson who complatad cause of death (Itam 23e) (Typa, Print): B. TURAKHIA, MD. 1009, Frederick Rd. Baltimore, MD 21228

State Registrar

31. Data filad *(Month, Day, Yaar)*: JAN 24 2001

32. Registrar's Signatura: [signature] D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0330-510
CJ
James Bochenek

amend item 23a,27,28a,b,c,d,e,f per me G791 1/31/01 yf

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01561

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Thomas Bochenek
2. Date of Death: Month: January Day: 20 Year: 2001
3. Time of Death: 11:52 A.M.

4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-08-9995
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 25 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8/7/1975
9. Birthplace (State or Foreign Country): South Korea

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Perry Hall
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 10 Bartley Ct.
10f. Zip Code: 21236
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Korean

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Store Clerk
16b. Kind of Business/Industry: Grocery

17. Father's Name (First, Middle, Last): Bernard Bochenek
18. Mother's Name (First, Middle, Maiden Surname): Andrea Gootee

19a. Informant's Name/Relationship (Type, Print): Bernard Bochenek/Father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 Bartley Ct. Perry Hall, Maryland 21236

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Balto./Wash. Crematory
Date: 1/24/01
20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Enter only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☑ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☒ Could not be determined

28a. Date of Injury (Month, Day, Year): found: 1/20/01
28b. Time of Injury: unknown M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: unknown
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): found at home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 3314 E. Lombard St., Baltimore, Md.

29a. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph Pestaner, M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): January 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: Jennie G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0333-003

GREGORY BLANKS

ASP amend item 8 per fh G792 2/2/01 yf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01562

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GREGORY BLANKS

2. Date of Death Month JANUARY Day 19 Year 2001

3. Time of Death: 1654

4a Facility Name *(If not institution, give street and number)*: NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 217-94-2606

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 35 Yrs. If Under 1 Yaar: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: FEB. 2, 1965

9. Birthplaca *(Stata or Foreign Country)*: MARYLAND

Usual Rasidance ot Decedant

10a. Stata: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: ODENTON

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 805 VACATION DRIVE

10f. Zip Code: 21113

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yas, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grada complatad)*: Elementary/Secondary (0-12): 12 / Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT use retired)*: TRUCK DRIVER

16b. Kind of Businass/Industry: TRANSPORTATION

17. Fathar's Nama *(First, Middla, Last)*: LESLIE HOWARD BLANKS

18. Mothar's Nama *(First, Middle, Maiden Surnama)*: PHODIE MAE OXENDINE

19a. Informant's Name/Ralationship *(Type, Print)*: ALESIA BLANKS / SISTER

19b. Mailing Address *(Straat and Number or Rural Route Number, City or Town, State, Zip Code)*: 805 VACATION DR., ODENTON, MARYLAND 21113

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Placa ot Disposition *(Nama of camatary, cramatory or other placa)*: TEN MILE CEN. BAP.CH.CEM. Data: JAN. 24 2001

20c. Location - City or Town, Stata: LUMBERTON, N.C.

21. Signatura of Funaral Sarvica Licansaa: [signature]

22. Nama and Addrass of Facility: KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complications that causad tha daath. Do not antar tha moda ot dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaan Onsat and Daath

Immadiata Causa (Finat diseasa or condition rasulting in daath): a. Contact Gunshot Wound of Head

Dua to (or as a consaquanca ot):

Sequantially tist conditions, if any, laading to immadiata cause. Enter Underlying Cause (Diseese or injury that initiatad avants rasulting in daath) Last:

b.

Dua to (or as a consaquanca ot):

c.

Dua to (or as a consaquanca ot):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying cause given in Part I.

23b. Did tobacco usa contributa to the causa of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yas 2 [ ] No

24b. Ware autopsy findings available prior to completion of cause of daath? 1 [X] Yas 2 [ ] No

25. Was casa ratarrad to medical axaminar? 1 [X] Yas 2 [ ] No

26. Placa ot Death *(Check only ona)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA. Other: 4 [ ] Nursing Homa 5 [ ] Rasidanca 8 [ ] Other *(Specify)*

27. Manner ot Death: 1 [ ] Natural 2 [ ] Accidant 3 [X] Suicida 4 [ ] Homicida 5 [ ] Pending invastigation 6 [ ] Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*: 1/19/01

28b. Tima of Injury: 1650 HRS

28c. Injury at Work? 1 [ ] Yas 2 [X] No

28d. Describa how injury occurrad: Subject shot self

28e. Placa of Injury - At homa, farm, streat, factory, office building, atc. *(Specify)*: street

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*: 939 1st Street Baltimore Maryland

29a. Cartifiar *(Check only one)*: 1 [ ] **Cartifying Physician:** To the best of my knowladga, death occurrad at tha time, data and placa, and due to tha causa(s) and mannar as stated. 2 [X] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurrad at the time, date and placa, and dua to tha cause(s) and mannar stated.

29b. Signatura and titla of cartifiar: [signature] MD

29c. Licansa number: O.C.M.E

29d. Data signad *(Month, Day, Yaar)*: JANUARY 21, 2001

30. Nama and addrass ot parson who completad causa of daath (Item 23a) (Type, Print): THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filad *(Month, Day, Yaar)*: JAN 24 2001

32. Registrar's Signatura: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01563

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Virginia Bossi

2. Date of Death — Month: January Day: 21 Year: 2001

3. Time of Death: 6:00 A.M.

4a. Facility Name *(If not institution, give street and number)*: Future Care Old Court

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-32-0149

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 93 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 2 1907

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Timonium

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2306 Chetwood RD APT 203

10f. Zip Code: 21093

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Home Maker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Franklin C. Koontz

18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret L. Rouskulp

19a. Informant's Name/Relationship *(Type, Print)*: Ronald Bossi Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1905 Calais Court Baltimore, MD 21244

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Balto-Wash. Crematory

Date: 01-22-01

20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee: Stephanie Ale

22. Name and Address of Facility: Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic cardiovascular disease — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Advanced dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)* — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Date of Injury *(Month, Day, Year)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)* 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: D Roggen

29c. License number: D35844

29d. Date signed *(Month, Day, Year)*: January 22 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): D Roggen 5400 Old Court Rd Randallstown MD 21133

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001

32. Registrar's Signature: B. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#20b perFHG791 1/24/2001 EW

Certificate of Death

Reg. No. 2001 01564

Charlotte Cromwell

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): Charlotte E. Cromwell
2. Date of Death (Month, Day, Year): January 22, 2001
3. Time of Death: 150pm
4a. Facility Name (If not institution, give street and number): Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:
5. Social Security Number: 217-38-3918
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 03 12 29
9. Birthplace (State or Foreign Country): M.D.

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1826 West Mosher Street
10f. Zip Code: 21217
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+): na
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Louis B. Frazier
18. Mother's Name (First, Middle, Maiden Surname): Sarah Dorsey

19a. Informant's Name/Relationship (Type, Print): Joan Cromwell-Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1826 West Mosher Street, Baltimore Md 21217

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore Nat. Cemet.
Date: 1/26/01
20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeral Service Licensee: Joan B. Frazier
22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death)
a. Respiratory Failure
Due to (or as a consequence of):
b. Malignant Pleural Effusion from Lung Metastasis
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Carcinoma of the Breast
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Shivani Negi
29c. License number: P14570
29d. Date signed (Month, Day, Year): 1/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Shivani Negi, M.D. 40 Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01565

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ASTON GEORGE CAMPBELL

2. Date of Death: Month JANUARY Day 22 Year 2001

3. Time of Death: 11 27 hrs.

4a. Facility Name (If not institution, give street and number): SAINT AGNES HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218 98 6962

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 59 Yrs.

If Under 1 Yeer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): FEB 14, 1941

9. Birthplace (State or Foreign Country): JAMAICA, W.I.

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 3906 WOODHAVEN AVE

10f. Zip Code: 21216

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Nevar Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Evar in U.S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yes, Giva Yaar or Datas:

13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highast grada complated)

Elementary/Secondary (0-12): 11TH grade

Collega (1-4or 5+):

16a. Decedent's Usual Occupetion (Give kind of work dona during most of working life. DO NOT use retired): INSPECTOR

16b. Kind of Business/Industry: BOOKING COMPANY

17. Father's Nama (First, Middle, Last): GEORGE CAMPBELL

18. Mothar's Nema (First, Middle, Maiden Sumama): JOSEPHINE CLARK

19a. Informant's Name/Ralationship (Type, Print): DESNE CAMPBELL / WIFE

19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda): 3906 WOODHAVEN AVE BALTIMORE, MARYLAND 2216

20a. Mathod of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify)

20b. Piece of Disposition (Nama of cematary, crametory or other place): WOODLAWN CEMETERY

Data: 1-27-2001

20c. Location - City or Town, State: WOODLAWN, MARYLAND

21. Signeture of Funaral Sarvice Licensea: Henry Harris

22. Nama and Address of Facility: CHATMAN-HARRIS FUNERAL HOME 5240 REISTERSTOWN ROAD BALTIMORE, MD 21215

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications thet caused the deeth. Do not anter the moda of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only one causa on aach lina.

Approximata Intarval Between Onset and Death

Immedieta Ceuse (Finel disaesa or condition resulting in death):

a. PROSTATE CANCER WITH BONY METASTASES — ONE YEAR

Due to (or es a consequence of):

b. ACUTE ON CHRONIC RENAL FAILURE — ONE MONTH

Sequantially list conditions, if sny, laading to immadiata cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last

Dua to (or as a consequanca of):

c. DEHYDRATION — ONE WEEK

Dua to (or as a consequance of):

d. HYPERKALAEMIA. — ONE DAY

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.

23b. Did tobacco use contributs to the cause of death? 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yas 2 ☒ No

24b. Wara autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was casa rafarred to medical examinar? 1 ☐ Yas 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpetiant 2 ☐ ER/Outpetient 3 ☐ DOA

Othar: 4 ☐ Nursing Hema 5 ☐ Rasidenca 8 ☐ Othar (Specify)

27. Mannar of Death: 1 ☒ Netural 2 ☐ Accidant 3 ☐ Suicide 4 ☐ Homicida 5 ☐ Panding Investigation 6 ☐ Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29e. Cartifiar (Check only one)

1 ☒ **Certifying Physician**: To tha best of my knowledga, daath occurred at tha tima, data and placa, snd dua to tha causa(s) and menner as stated.

2 ☐ **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, deeth occurred at the tima, data snd placa, and due to tha cause(s) and menner steted.

29b. Signature and title of certifier: RESIDENT

29c. Licensa number: P-12598

29d. Data signed (Month, Day, Year): JANUARY 22 2001

30. Nama and addrass of person who complated causa of daath (Item 23a) (Type, Print): SIMEON OBENG, 900 CATON AVE, BALTIMORE MD 21229.

State Registrar

31. Data filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signature: Geneva D. Sparks

DHMH 16 Rsv 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME CAMPBELL, ASTON

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01566

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN CARPENTER

2. Date of Death — Month: JANUARY Day: 22 Year: 2001

3. Time of Death: 5 10 PM

4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-16-1517

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 78 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): OCT. 1, 1922

9. Birthplace (State or Foreign Country): unk

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: RANDALLSTOWN

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 9109 LIBERTY ROAD

10f. Zip Code: 21133

10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: AFRICAN AMERICAN

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): unk — College (1-4or 5+): unk

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk

16b. Kind of Business/Industry: unk

17. Father's Name (First, Middle, Last): unk

18. Mother's Name (First, Middle, Maiden Surname): unk

19a. Informant's Name/Relationship (Type, Print): DEBORAH HAMILTON (GUARDIAN)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 N. CALVERT STREET 3rd FL. BALTIMORE, MD 21202

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEMETERY — Date: 1/24/01

20c. Location - City or Town, State: LANSDOWNE. MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS

Due to (or as a consequence of):
b. PNEUMONIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] C. RAVI MD

29c. License number: D37333

29d. Date signed (Month, Day, Year): JANUARY 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C. RAVI MD, NHC, BALTO. MD 21133

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

2

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01567

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DORTHA E. COLEBANK
2. Date of Death: Month 01 Day 21 Year 2001
3. Time of Death: 9 50 AM
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 219-20-9868
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 1, 1917
9. Birthplace (State or Foreign Country): WEST VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: BROOKLYN PARK
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 611 WOOD STREET
10f. Zip Code: 21225
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CLAIMS INVESTIGATOR
16b. Kind of Business/Industry: STATE GOVERNMENT

17. Father's Name (First, Middle, Last): HARRISON FISHER
18. Mother's Name (First, Middle, Maiden Surname): PRISCILLA MCGEE

19a. Informant's Name/Relationship (Type, Print): ROLINDA K. MUELLER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 611 WOOD ST., BROOKLYN PARK, MARYLAND 21225

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CEDAR HILL CEMETERY
Date: JAN. 26 2001
20c. Location - City or Town, State: BROOKLYN PARK, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Bilateral pneumonia
Due to (or as a consequence of):
b. Sepsis
Due to (or as a consequence of):
c. gram positive cocci Bacteremia
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Congestive heart failure
Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] M.D
29c. License number: 042820
29d. Date signed (Month, Day, Year): 1/21/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHRISTOPHER deBORJA 3708 Mountain Rd., PASADENA Md. 21122

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01568

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
STEVE	CHRISTI		JANUARY 22 2001	16:20

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
JOHNS HOPKINS BAYVIEW MEDICAL CENTER	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
235-32-9344	1☒ M 2☐ F	75 Yrs.			10/10/1925	WV

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
WV	Hancock	Weirton	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1318 Overlook Drive	26062	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Salesman	Sears

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Nicholas Christi	Persifoni Papastamati

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mary Georgiou Sister	110 Franklin Ave. Baltimore, MD 21225

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Oaklawn Cemetery	01/25/01	Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ Robert J. Bradley

22. Name and Address of Facility: Bradley Ashton Matthews Funeral Home, Inc. 2134 Willow Spring RD Baltimore, MD 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. small cell lung cancer	6 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Jeffrey a. Rumbaugh, MD	RES-000	January 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 4940 EASTERN AVENUE BALTIMORE, MD 21244 JEFFREY A. RUMBAUGH

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 24 2001	Lenore B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01569

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CARMELLA CIRILLO
2. Date of Death: Month January Day 18 Year 2001
3. Time of Death: 3 A.M.
4a. Facility Name (If not institution, give street and number): Future Care Canton Harbor
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-22-9895
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): 04-01-25
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedant

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 2804 Fairmount Ave.
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 0 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Never Worked
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): Unitario Cirillo
18. Mother's Name (First, Middle, Maiden Surneme): Rose Meli

19a. Informent's Name/Relationship (Type, Print): Maria Nueslein
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 2804 Fairmount Ave. Baltimore, MD 21224

20a. Method of Disposition: 1☒Burial 2☐Cramation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Piece of Disposition (Neme of cemetary, cremetory or other piece): Most Holy Redeemer Cem.
Date: 01/20/01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee ▶
22. Nama and Address of Facility: Moran Ashton Funeral Home 3000 East Baltimore St. Baltimore, MD 21224

Physician /Medical Examiner

23a. Part I. Enter the diseases, injuries, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Senile dementia — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last
b.
Due to (or es a consequence ot):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
Hypertension
Gastric outlet obstructing

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an eutopsy performed? 1☐Yes 2☒No
24b. Were eutopsy findings available prior to completion of causa ot death? 1☐Yes 2☐No

25. Was cese referred to medical examinar? 1☐Yes 2☒No
26. Place ot Death (Check only one): Hospital: 1☐Inpatiant 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Othar (Specify)

27. Manner of Death: 1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best ot my knowledge, death occurred at the time, date end piece, and due to the cause(s) end menner es stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted.

29b. Signeture and title of certifier ▶ Jonn G. Dreyer
29c. License number: D0001442
29d. Data signed (Month, Dey, Year): 01-19-01

30. Name and address ot person who completed ceuse of death (Item 23a) (Type, Print): LOUIS E GOENZLER M.D. 301 S PAUL PL #815 BALTO MD 21202

State Registrar

31. Date filed (Month, Dey, Year): JAN 24 2001
32. Registrar's Signature ▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #8 PER F.H. G791 1-24-01 WR .

Certificate of Death

Reg. No. 2001 01570

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SAMUIL CHERNYAKOV

2. Date of Death Month / Day / Year: JANUARY 22ND 2001

3. Time of Death: 1:00 AM

4a. Facility Name *(If not institution, give street and number)*: NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 213-96-4286

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JAN 11 1911

9. Birthplace *(State or Foreign Country)*: RUSSIA

To Be Completed by Funeral Director

Usual Residence of Decedant

10a. Steta: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Insida City Limits: 1☒Yes 2☐No

10a. Street and Number: 6968 MARSUE DRIVE APT.2-D

10f. Zip Code: 21215

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Marriad 2☐Merried 3☒Widowed 4☐Divorced

12. Wes Decedent Ever In U.S. Armed Forces? 1☐Yas 2☒No
If Yas, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.)
1☐Yes 2☒No *Specify:*

14. Race - Amaricen Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*
Elemantary/Secondary (0-12):
College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ELECTRICAL CONTRACTOR

16b. Kind of Business/Industry: BUILDING

17. Fathar's Name *(First, Middle, Last)*: HANON CHERNYAKOV

18. Mothar's Nama *(First, Middle, Maiden Surnama)*: BELLA HECKS

19a. Informant's Name/Relationship *(Type, Print)*: SOPHIA SOKOLIN/DAUGHTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 3314 LEE COURT BALTIMORE,MD. 21208

20a. Method of Disposition: 1☒Burial 2☐Cramation 3☐Removal from Stete 4☐Donation 5☐Othar *(Specify)*

20b. Place of Disposition *(Name of cemetary, cramatory or other place)*: ARLINGTON-CHIZUK AMUNO

Data: 1/23/01

20c. Location - City or Town, Stata: BALTIMORE, MD.

21. Signature and Funeral Service Licensee: Jay Alan L...

22. Name and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet ceused the death. Do not anter the mode of dying, such as cerdiac or raspiratory arrest, shock, or heart failura. List only one cause on aach lina.

Approximete Interval Between Onset and Deeth

Immediata Causa (Final disaasa or condition resulting in death)
a. PNEUMONIA
Due to (or as a consequance of):

Sequentially list conditions, if any, laeding to immadiata causa. Enter Underlying Ceusa (Disease or injury thet initieted evants resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying ceusa givan in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

CEREBROVASCULAR ACCIDENT

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yas 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was cesa refarred to medicel examiner? 1☐Yas 2☒No

26. Place of Death *(Check only one)*
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Homa 5☐Residance 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Panding investigetion 6☐Could not be datarmined

28a. Date of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*
1☒**Certifying Physician:** To the best of my knowledge, death occurred at tha tima, data and place, and dua to tha ceuse(s) and mannar as stated.
2☐**Medical Examiner:** On tha basis of examination and/or investigetion, in my opinion, deeth occurred at the tima, data and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: MD

29c. License number: D42723

29d. Date signed *(Month, Day, Year)*: JANUARY 22ND 2001

30. Nama and address of person who completed ceuse of daath (Item 23a) (Type, Print): AYYERAHALLI M HARISH NORTHWEST HOSPITAL CENTER 5401 OLD COURT ROAD MD 21133

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 24 2001

32. Registrar's Signature: Jeanne D. Lewis

FEB 8 2001

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-0313-510
LRB
JENNIFER DURM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM #16b per fh G791 012401 SS

Certificate of Death

Reg. No. 2001 01571

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jennifer Colleen Durm

2. Date of Death (Month, Day, Year): January 19, 2001

3. Time of Death: 12:02 P.M.

4a. Facility Name (If not institution, give street and number): University of Maryland Hospital S.T.U.

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-94-6122

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 22 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 28, 1978

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Lansdowne

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 320 Wisewell Ct.

10f. Zip Code: 21227

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Retail

16b. Kind of Business/Industry: Clerical ~~Clerical~~

17. Father's Name (First, Middle, Last): Charles W. Durm

18. Mother's Name (First, Middle, Maiden Surname): Norma Jean Davenport

19a. Informant's Name/Relationship (Type, Print): Scott Garrity, Grandfather

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 320 Wisewell Ct. Lansdowne, MD. 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Memorial Park

Date: 1-24-01

20c. Location - City or Town, State: Glen Burnie, MD

21. Signature of Funeral Service Licensee: Rebecca Rhison

22. Name and Address of Facility: Ambrose Funeral Home 1328 Sulphur Spring, Rd. Arbutus, MD. 21227

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year): 1/19/01

28b. Time of Injury: 9:25AM

28c. Injury at Work? 1☐ Yes 2☑ No

28d. Describe how injury occurred: Driver of Motor vehicle Impacts Fixed Objects

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Street

28f. Location (Street and Number or Rural Route Number, City or Town, State): Interstate 97 Anne Arundel County, Maryland

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph Pestaner M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): January 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signature: Geneva G Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01572

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): REGINA DUFFY
2. Date of Death: Month JAN. Day 23 Year 2001
3. Time of Death: 0245
4a. Facility Name (If not institution, give street and number): HOWARD COUNTY GENGRAL HOSP
4b. City, Town, or Location of Death: COLUMBIA
4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 215-22-0700
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 6, 1907
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3542 Church Road
10f. Zip Code: 21043
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesperson
16b. Kind of Business/Industry: Women's Clothing

17. Father's Name (First, Middle, Last): Howard Kirby
18. Mother's Name (First, Middle, Maiden Surname): Ella Butler

19a. Informant's Name/Relationship (Type, Print): William M. Duffy / son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3542 Church Road, Ellicott City, Maryland 21043

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): New Cathedral Cemetery
Date: 1/26/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Juanita R Thomas
22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	SEPSIS	1 DAY
Due to (or as a consequence of): b.	PNEUMONIA	4 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	CONGESTIVE HEART FAILURE	REMOTE
Due to (or as a consequence of): d.	CORONARY ATHEROSCLEROSIS.	REMOTE

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION

HYPERTENSION.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D42680
29d. Date signed (Month, Day, Year): JAN 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SABA SHAIKH MD. 9051 BALTIMORE NAT'L PIKE. ELLICOTT CITY MD 21042

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature

ORIGINAL

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01573

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas Downs

2. Data of Death: Month 1 Day 23 Year 01

3. Time of Death: 1319

4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 218-42-7062

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 53 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Oct 10, 1947

9. Birthplaca (State or Foraign Country): Maryland

Usual Residence of Decedant

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Crownsville

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 112 Summer Hill Park

10f. Zip Coda: 21032

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Nevar Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☒Yas 2☐No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1☐Yas 2☒No Specify:

14. Race - American Indian, Black, Whita, etc. Specify: White

15. Decedent's Educatlon (Specify only highast grada completed): Elementary/Secondary (0-12): 12 | Collega (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired): Contractor

16b. Kind of Business/Industry: Purchasing

17. Fathar's Nama (First, Middla, Last): Richard E. Downs

18. Mothar's Nama (First, Middla, Maidan Surname): Elizabeth Tucker

19a. Informant's Name/Ralationship (Type, Print): Joann P. Downs / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda): 112 Summer Hill Park, Crownsville, Maryland 21032

20a. Mathod of Disposition: 1☒Burial 2☐Cramation 3☐Ramoval from Stata 4☐Donatlon 5☐Other (Specify)

20b. Place of Disposition (Nama of cematary, cramatory or other place): Henlopen Memorial Park

Data: 1/27/01

20c. Location - City or Town, Stata: Milton, Delaware

21. Signature of Funaral Service Licensee: [signature]

22. Nama and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part1. Entar tha disaase, or complications that ceused tha daath. Do not antar tha moda of dying, such as cardiac or respiretory arrest, shock, or haart failure. List only one causa on aach lina.

Approximate Intarval Batween Onsat and Death

Immediate Cause (Final disease or condition resulting in death): a. Myocardial Infarction — 24hrs

Dua to (or as a consequance of):

Sequantially list conditions, if any, leading to immadiate cause. Enter Undarlying Cause (Diseasa or injury that initiated evants rasulting in death) Last:

b. Dua to (or as a consequance of):

c. Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying ceusa givan in Part I.: Diabetes

23b. Did tobacco uss contributs to the causs of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Wara autopsy findings available prior to compltion of cause of death? 1☐Yas 2☑No

25. Was casa raferred to medical examinar? 1☐Yas 2☑No

26. Placa of Daath (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Rasidance 8☐Othar (Specify)

27. Manner of Death: 1☐Naturel 2☐Accidant 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be datarmined

28a. Date of Injury (Month, Day Yaar)

28b. Time of Injury M

28c. Injury at Work? 1☐Yas 2☐No

28d. Describe how injury occurred

28a. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To tha best of my knowledga, death occurred at tha time, data and place, and dua to tha cause(s) and mannar as stated. 2☐**Medical Examiner:** On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at tha time, dete and place, and dua to tha ceuse(s) and manner stated.

29b. Signature and title of certifier: Dr. Wermt MD

29c. License number: 038445

29d. Data signed (Month, Day, Year): Jan 23, 2001

30. Name and address of person who completed ceusa of death (Item 23a) (Type, Print): Ira Wermsen Medically Art Annapolis MD 21401

State Registrar

31. Data filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0365-510
LRB
ROBERTO DANEKER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND# 23,27&28a-f per ME G793 030901 SS

Certificate of Death

Reg. No. 2001 01574

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Roberto F. Daneker
2. Date of Death (Month, Day, Year): January 22, 2001
3. Time of Death: 8:29 P.M.
4a. Facility Name (If not institution, give street and number): University of Maryland Hospital S.T.U.
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-50-6659
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 50 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 6, 1950
9. Birthplace (State or Foreign Country): Germany

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1520 East Fort Avenue
10f. Zip Code: 21230
10g. Citizen of What Country: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Yeer or Detes: Army 69-71
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Artist
16b. Kind of Business/Industry: Arts
17. Father's Neme (First, Middle, Last): James William Daneker
18. Mother's Name (First, Middle, Meiden Surneme): Mary Martha Hennen
19a. Informant's Name/Relationship (Type, Print): Dianne G. DeSantis / Sister
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 1520 East Fort Avenue, Baltimore MD 21230
20e. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removel from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Bayview Crematory — Dete: Jan. 24, 2001
20c. Location - City or Town, State: Baltimore Maryland
21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.
22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilura. List only one ceuse on each line. (Approximate Interval Between Onset end Death)

Immediate Ceuse (Finat disease or condition resulting In death): a. ALCOHOL INTOXICATION COMPLICATED BY HEAD INJURIES

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting In death) Last

b.

Due to (or es e consequance of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospitel: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)

27. Menner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined

28a. Date of Injury (Mooth, Dey Year): found: 1-22-01
28b. Time of Injury: found: 7:45 PM
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: subject drank alcohol and fell down stairs
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify): residence
28f. Location (Street end Number or Rurel Route Number, City or Town, State): 1520 East Fort Ave., Balto., MD

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) end manner as stated. 2 [X] Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): January 23, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. King — 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01575

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Karen C Dorsey
2. Date of Death (Month, Day, Year): January 21, 2001
3. Time of Death: 11 55 Am
4a. Facility Name *(If not institution, give street and number)*: Mercy Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 215-84-3698
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 38 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 03-23-62
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: ☒ Yes 2☐ No
10e. Street and Number: 2604 East Fayette Street
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: ☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th Grade | College (1-4or 5+): NA
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Dietian Assistance
16b. Kind of Business/Industry: Manor Care

17. Father's Name *(First, Middle, Last)*: James Terry
18. Mother's Name *(First, Middle, Maiden Surname)*: Adelaide Dorsey

19a. Informant's Name/Relationship *(Type, Print)*: Janet Stearns
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2346 E. Fayette Street Baltimore, MD. 21224

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Greenmount Cem. | Date: 01-27-2001
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: WM.C.March FH 1101 E. North Avenue Baltimore, Maryland 21202

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Acute Respiratory distress syndrome — days
Due to (or as a consequence of):
b. pneumococcal pneumonia and bacteremia — days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Severe diabetic KetoAcidosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D37790
29d. Date signed *(Month, Day, Year)*: January 21, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nevins W Todd M.D. 301 St Paul Place Baltimore 21202

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001
32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

DHMH 16 Rev 6/95

ORIGINAL

01-0070-025
LRB
RajPal Dillon

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G791 1-30-01 WR

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01576

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RAJPAL DILLON
2. Date of Death: Month January Day 04 Year 2001
3. Time of Death: 2:40 P.M.

4a. Facility Name (If not institution, give street and number): Upper Chesapeke Medical Center
4b. City, Town, or Location of Death: Belair
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 367 64 0317
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 53 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 5, 1947
9. Birthplace (State or Foreign Country): INDIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: HARFORD
10c. City, Town or Location: BEL AIR
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1003 SHAFFNER DRIVE
10f. Zip Code: 21014
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: ASIAN INDIAN

15. Decedent's Education (Specify only highest grade completed)
Elementery/Secondary (0-12): 12YRS.
College (1-4or 5+): 5 YRS.
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ENGINEER
16b. Kind of Business/Industry: U.S. FED. GOVT. - DEPT. OF PUBLIC WORKS

17. Father's Name (First, Middle, Last): MOHAN S. DHILLON
18. Mother's Name (First, Middle, Meiden Surname): TEJ K. JUDGE

19a. Informant's Neme/Relationship (Type, Print): SURINDER DILLON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21014: 1003 SHAFFNER DRIVE BEL AIR, MARYLAND

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other place): EVANS FUNERAL CHAPEL-BEL AIR, P.A.
Date: JAN 7, 2001
20c. Location - City or Town, State: FOREST HILL MARYLAND

21. Signature of Funeral Service Licensee
22. Name and Address of Facility: EVANS FUNERAL CHAPEL-BEL AIR, P.A. 21050
3 NEWPORT DRIVE FOREST HILL, MARYLAND

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): a. ASPHYXIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. PLACEMENT OF PLASTIC BAG OVER HEAD
Due to (or es a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Netural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year): 1-4-01
28b. Time of Injury: UNKNOWN M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: SUBJECT PLACE PLASTIC BAG OVER HIS HEAD
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify): RESIDENCE
28f. Location (Street and Number or Rural Route Number, City or Town, State): 1003 SHAFFNER DR. BELAIR, MARYLAND

29e. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examinetion and/or Investigetion, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis J. Chute M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): January 05, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit copy.

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0345-005
B.K.S

ROBERT DAVIS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01577

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert John Davis
2. Date of Death (Month, Day, Year): JAN. 21, 2001
3. Time of Death: 0945 AM
4a. Facility Name (If not institution, give street and number): 2333 FOSTER AVENUE
4b. City, Town, or Location of Death: PARKVILLE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 213-54-2496
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 51 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 15 1950
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2333 Foster Ave.
10f. Zip Code: 21234
10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): warehouse
16b. Kind of Business/Industry: Allen Tractor Corp.

17. Father's Name (First, Middle, Last): John Davis, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Marie Williams

19a. Informant's Name/Relationship (Type, Print): Susan Williams sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3325 Brengar Rd. Street Md 21154

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Moreland Mem Park
Date: Jan 25 2001
20c. Location - City or Town, State: Parkville Maryland

21. Signature of Funeral Service Licensee: Krista L. Wells
22. Name and Address of Facility: EVANS Funeral Chapel 8800 Harford Rd. Baltimore Md 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Atherosclerotic Cardiovascular

Due to (or as a consequence of):
b. Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [✓] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [✓] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) AT SCENE

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J Pestaner, M.D
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): JAN 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01578

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CURZON H. DEFORD

2. Date of Death (Month, Day, Year): JANUARY 16, 2001

3. Time of Death: 8:20 AM

4a. Facility Name (If not institution, give street and number): GENESIS LONG GREEN

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-46-2069

6. Sex: XX 1 M 2 F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 05-14-1916

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: XX 1 Yes 2 No

10e. Street and Number: 115 EAST MELROSE AVENUE

10f. Zip Code: 21212

10g. Citizen of What Country?: U.S.A.

11. Marital Status: XX Never Married 2 Married 3 Widowed 4 Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 Yes XX No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Yes XX No Specify:

14. Rece - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): - 0 -

College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): MENTALLY RETARDED

16b. Kind of Business/Industry: NONE

17. Father's Name (First, Middle, Last): ROBERT B. DEFORD

18. Mother's Neme (First, Middle, Maiden Surname): DOROTHEA HOFFMAN

19a. Informant's Name/Relationship (Type, Print): MRS. JONATHAN DEFORD (NIECE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O.BOX 5003, GLEN ARM, MARYLAND, 21057

20a. Method of Disposition: 1 Burial XX Cremation 3 Removel from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): GREEN MOUNT CREMATORY

Dete: 1-17

20c. Location - City or Town, State: BALTIMORE, MD. 21202

21. Signature of Funeral Service Licensee: William R. Cawthorn

22. Name and Address of Fecility: HENRY W. JENKINS AND SONS COMPANY 6500 YORK ROAD, BALTIMORE, MARYLAND, 21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE — ONE HOUR

Due to (or as a consequence of):

b. POSSIBLE ACUTE MYOCARDIAL INFARCTION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest

Due to (or as a consequenca of):

c.

Due to (or as a consequenca of):

d.

Part fI. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

SEIZURE DISORDER

OBESITY

23b. Did tobacco use contribute to the cause of death? 1 Yes XX No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes XX No

24b. Ware autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes XX No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Other: XX Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death: XX Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): XX **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner es ated. 2 **Medical Examiner:** On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William D. McConnell MD

29c. License number: D 42129

29d. Dete signed (Month, Day, Year): JANUARY 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM D. McCONNELL M.D., 500 W. UNIVERSITY PARKWAY, BALTO., MD. 21210

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signature: [signature] ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#5 PER F.H. G792 2-6-2001 JAB

Certificate of Death

Reg. No. 2001 01579

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lillian Eline

2. Date of Death (Month, Day, Year): JANUARY 23, 2001

3. Time of Death: 8:59 PM

4a. Facility Name *(If not institution, give street and number)*: Mercy Hospital Stella Maris

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-10-~~8741~~ 9741

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 13, 1918

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2833 Louisiana Ave.

10f. Zip Code: 21227

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Charles High

18. Mother's Name *(First, Middle, Maiden Surname)*: Laura Lavinia Andrews

19a. Informent's Name/Relationship *(Type, Print)*: Lillian Hartman, Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9378 Paulskirk Dr. Ellicott City, MD. 21042

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MD Veteran's Cemetery

Date: 1-26-01

20c. Location - City or Town, State: Crownsville, MD

21. Signature of Funeral Service Licensee: Rebecca Robinson

22. Name and Address of Facility: Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Arbutus, MD. 21227

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. End Stage Cardiac Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D40854

29d. Date signed *(Month, Day, Year)*: JANUARY 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St Paul Pl Baltimore MD 21202

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01580

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BENJAMIN EISENMAN
2. Date of Death Month Day Year: JANUARY 11, 2001
3. Time of Death: 15:25
4a. Facility Name *(If not institution, give street and number)*: HOLY CROSS HOSPITAL
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 579.30.8283
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 73 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MARCH 13, 1927
9. Birthplace *(State or Foreign Country)*: WASHINGTON, DC

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: ROCKVILLE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 6111 MONTROSE ROAD
10f. Zip Code: 20852
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: BUSINESS BROKER
16b. Kind of Business/Industry: BROKER

17. Father's Name *(First, Middle, Last)*: HARRY EISENMAN
18. Mother's Name *(First, Middle, Maiden Surname)*: MARY MUROCHNICK

19a. Informant's Name/Relationship *(Type, Print)*: ARTHUR LEIBMAN/BROTHER IN LAW
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8508 VICTORY LANE, POTOMAC, MARYLAND 20854

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: KING DAVID MEMORIAL GDNS
Date: JAN 14, 2001
20c. Location - City or Town, State: FALLS CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MASSIVE PLEURAL EFFUSION — 2 WEEKS
Due to (or as a consequence of):
b. PROBABLE MALIGNANCY — UNKNOWN

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION
DIABETES MELLITUS
CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D0045121
29d. Date signed *(Month, Day, Year)*: 1/11/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BRIAN F. REAGAN, MD 1500 FOREST GLEN AVENUE, SILVER SPRING, MARYLAND 20902

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001
32. Registrar's Signature: [signature]

ORIGINAL

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01581

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Fitzpatrick
2. Date of Death (Month, Day, Year): JANUARY 17, 2001
3. Time of Death: 10:30 AM
4a. Facility Name (If not institution, give street and number): Home - 633 Rappolla Street
4b. City, Town, or Location of Death: Baltimore 21224
4c. County of Death: Balto. City

Funeral Director

5. Social Security Number: 213-34-0142
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 64 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APR. 14, 1936
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 633 RAPPOLLA ST.
10f. Zip Code: 21205
10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forcas?: 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 11TH; College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): MACHINE OPERATOR
16b. Kind of Business/Industry: WESTERN ELECTRIC

17. Father's Neme (First, Middle, Last): JOSEPH B. FITZPATRICK, SR.
18. Mother's Name (First, Middle, Meiden Surname): NELLIE SCHWARTZ

19a. Informent's Neme/Reletionship (Type, Print): BARBARA FITZPATRICK/WIFE
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 525 N. CURLEY ST., BALTIMORE, MD. 21224

20e. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): BALTIMORE WASHINGTON CREMATORY
Dete: 1/22/01
20c. Location - City or Town, Stete: LAUREL, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MD 21224

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory erfrest, shock, or heart feilure. List only one cause on eech line.

		Approximate Interval Between Onset and Deeth
Immediate Cause (Finel disease or condition resulting in death) e.	Hepatoma	15 yrs
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last b.		
Due to (or es a consequence of):		
c.		
Due to (or es a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner es stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: [signature]
29c. License number: D34532
29d. Dete signed (Month, Day, Year): 01/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID A VAN ECK, MD 22 South Greene Street Baltimore, MD

State Registrar

31. Dete filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01582

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas George Fisher, Jr.
2. Date of Death (Month, Day, Year): Jan 19 2001
3. Time of Death: 10 A.M.
4a. Facility Name (If not institution, give street and number): 1109 Sharon Acres Rd.
4b. City, Town, or Location of Death: Jarrettsville
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 214-40-6747
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 57 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 10 1943
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: Harford
10c. City, Town or Location: Jarrettsville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1109 Sharon Acres Rd.
10f. Zip Code: 21084
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): glass installer
16b. Kind of Business/Industry: Accurate Weatherstrip & Screen Com.

17. Father's Name (First, Middle, Last): Thomas G. Fisher, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Dolores Beikirch

19a. Informant's Name/Relationship (Type, Print): Vera Y. Fisher
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1109 Sharon Acres Rd Jarrettsville Md 21084

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Highview Cemetery | Date: Jan. 22 2001
20c. Location - City or Town, State: Fallston, Maryland

21. Signature of Funeral Service Licensee: Krista S. Wells
22. Name and Address of Facility: Evans Funeral Chapel 3 Newport Dr. Forest Hill, Md 21050

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PANCREATIC CANCER	3 MONTHS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R. Phillips
29c. License number: D22843
29d. Date signed (Month, Day, Year): January 19 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): R. PHILLIPS 2005 RUCK SPRING RD FOREST HILL MD 21050

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: Penny G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01583

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Funke
2. Date of Death (Month, Day, Year): Jan 20 2001
3. Time of Death: 4:33pm
4a. Facility Name (If not institution, give street and number): Veterans Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 216209427
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 75 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV 23, 1925
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: SPARROWS POINT
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7218 BAYFRONT ROAD
10f. Zip Code: 21219
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DRIVER
16b. Kind of Business/Industry: AUTOMOTIVE

17. Father's Name (First, Middle, Last): WILLIAM A. FUNKE
18. Mother's Name (First, Middle, Maiden Surname): ANN KOENIG

19a. Informant's Name/Relationship (Type, Print): PHYLLIS SCHULTZ / STEP-DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7218 BAYFRONT ROAD BALTIMORE, MD 21219

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY
Date: 1/22/01
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, MD 21237

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Emphysema
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b. Aortic dissection
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [X] **Yes** 2 [ ] **No** 3 [ ] **Probably** 4 [ ] **Unknown**

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: p1605
29d. Date signed (Month, Day, Year): Jan 20 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert L. Li 22 South Green St, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: Barbara G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

AMENDED ITEM #14 per fh G791 012401 SS

Reg. No. 2001 01584

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JEANETTE GRANOWITCH

2. Date of Death (Month, Day, Year): January 23, 2001

3. Time of Death: 504 am

4a. Facility Name (If not institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: NA

Funeral Director

5. Social Security Number: 220-76-1834

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG. 4, 1911

9. Birthplace (State or Foreign Country): unk

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1217 W. FAYETTE STREET

10f. Zip Code: 21223

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. white. Specify: ~~AFRICAN~~ ~~AMERICAN~~

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unk; College (1-4or 5+): unk

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk

16b. Kind of Business/Industry: unk

17. Father's Name (First, Middle, Last): unk

18. Mother's Name (First, Middle, Maiden Surname): unk

19a. Informant's Name/Relationship (Type, Print): CARLA RANSOM (GUARDIAN)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 861 PARK AVENUE BALTIMORE, MD 21201

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEMETERY

Date: 1/23/01

20c. Location - City or Town, State: LANSDOWNE, MD

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: WYLIE FUNERAL HOME PA
638 N. GILMOR STREET BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

b. Urinary Tract Infection

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Mental Retardation

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: P 14582

29d. Date signed (Month, Day, Year): 1/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Constance Nduaguba, M.D. c/o Maryland General Hospital.

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signature: ▶ [signature] D. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Jeanette Granowitch
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

8

3

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01585

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LEE EDWARD GLASS
2. Date of Death (Month, Day, Year): JANUARY 19 2001
3. Time of Death: 6:30AM
4a. Facility Name (If not institution, give street and number): 4115 MARY AVENUE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 242-54-2268
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 11, 1940
9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 4115 MARY AVENUE
10f. Zip Code: 21206
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? [X] Yes 2 [ ] No If Yes, Give Year or Dates: VIETNAM
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): RESTUARANT MANAGER/SUPERVISOR
16b. Kind of Business/Industry: HORN & HORN
17. Father's Name (First, Middle, Last): UNKNOWN GLASS
18. Mother's Name (First, Middle, Maiden Surname): NORVIL (KEMP)
19a. Informant's Name/Relationship (Type, Print): BONNIE LEE GLASS (WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4115 MARY AVENUE BALTIMORE, MD 21206
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): METRO CREMATORY
Date: 1/20/01
20c. Location - City or Town, State: CATONSVILLE, MD
21. Signature of Funeral Service Licensee: Sharon
22. Name and Address of Facility: CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE CATONSVILLE, MD 21237

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Ventricular arrhythmia	acute
Due to (or as a consequence of): b.	Ischemic heart disease	chronic
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Duncan Salmon
29c. License number: D25733
29d. Date signed (Month, Day, Year): 1/19/2001

30. Name and address of person who completed cause of death (item 23a) (Type, Print): Ducan Salmon, M.D. 5601 Loch Raven Blvd. Baltimore, MD 21239

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

VOID

CERTIFICATE #

01-01586

SEE

CERTIFICATE #

00-43646

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01587

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Marion L. Hitzelberger
2. Date of Death Month Day Year: January 14, 2001
3. Time of Death: 8:22 p.m.
4a. Facility Name *(If not institution, give street end number)*: 3760 Bay Road
4b. City, Town, or Location of Death: Street
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 212-18-5187
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 20, 1920
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Street
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 3760 Bay Road
10f. Zip Code: 21154
10g. Citizen of What Country?: U.S.A.

11. Maritel Status: 1☐Never Married 2☐Merried 3☒Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11th. Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Supervisor
16b. Kind of Business/Industry: Ship Yard

17. Father's Name *(First, Middle, Last)*: William Francis Hitzelberger
18. Mother's Name *(First, Middle, Maiden Surname)*: Helen Laisure

19a. Informant's Name/Relationship *(Type, Print)*: Jeanne Hitzelberger/Daughter
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 4627 Mary Avenue Baltimore MD 21206

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Gardens Of Faith Cem.
Dete: 1/18/2001
20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: [signature]
22. Neme end Address of Facility: John C. Miller, Inc. 6415 Belair Road Baltimore MD 21206

Physician /Medical Examiner

23a. Part I. Enter the disease or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on eech tine. — Approximete Intervet Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
a. Cerebral Vascular Accident — 2 weeks
Due to (or as a consequenca of):
b.
Sequentiatly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or es a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Recent Deep Venous Thrombosis

23b. Did tobacco use contributs to the causes of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was en autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Wes case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death *(Check only one)*: Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigetion 6☐Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] David S Dunn
29c. License number: D32299
29d. Date signed *(Month, Day, Year)*: January 17,2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Dr. David Dunn 615 W. McPhail Road Suite 106 Belair MD

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 24 2001
32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

RKD

01-0299-025

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

SHURLA IVORY amend item 23a,27 per me G791 1/31/01 yf

AMEND ITEM: #18 PER F.H. G791 1-26-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01588

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SHURLA Victoria Ivory
2. Date of Death: Month JANUARY Day 18 Year 2001
3. Time of Death: 8:01A.M.
4a. Facility Name (If not institution, give street and number): HARFORD MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: HAVRE DE GRACE
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 215-33-9179
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 35 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar. 31, 1965
9. Birthplace (State or Foreign Country): TRINIDAD-TABAGO

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: ABERDEEN
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 2793 Dock Ct #A
10f. Zip Code: 21005
10g. Citizen of What Country? USA

11. Meritel Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedant Evar in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yaar or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Rece - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 1 YEAR
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry: MEDICS SCHOOL

17. Father's Name (First, Middle, Last): Octavius Henry
18. Mother's Neme (First, Middle, Maiden Surneme): MURIEL JOHN

1 5 2000

19a. Informent's Neme/Reletionship (Type, Print): DEXTER Ivory / HUSBAND
19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21005: 2793 Dock Ct #A ABERDEEN, Maryland
20a. Method of Disposition: 1☒Buriel 2☐Crametion 3☐Removel from Stete 4☐Donation 5☐Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): SIPARIA Cemetery
Dete:
20c. Location - City or Town, Stata: TRINIDAD - TABAGO
21. Signeture of Funeral Service Licensee: Jerry Harris
22. Neme end Addrass of Facility: CHAPMAN HARRIS Funeral Home, 5240 REISTERSTOWN ROAD, BALTIMORE, Maryland 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line. — Approximate Interval Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in death): a. CARDIAC ARRHYTHMIA ASSOCIATED WITH PANHYPOPITUITARISM

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Dua to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes en autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of causa of deeth? 1☒Yes 2☐No

25. Was case referred to medicel exeminer? 1☒Yes 2☐No

26. Place of Death (Check only one): Hospitel: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Othar (Specify)

27. Manner of Death: 1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending invastigetion 6☐Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office buliding, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stephen S. Radentz, M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): JANUARY 19, 2001

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01589

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DONNA · M. ISAACS

2. Date of Death — Month: JANUARY Day: 22 Year: 2001

3. Time of Death: 5:20 PM

4a. Facility Name (If not institution, give street and number): HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death: COLUMBIA

4c. County of Death: HOWARD.

Funeral Director

5. Social Security Number: 506-22-6541

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth (Month, Day, Year): MAY 6, 1924

9. Birthplace (State or Foreign Country): NEB.

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3009 ORLANDO AVE

10f. Zip Code: 21234

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+): MA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): IBM OPERATOR

16b. Kind of Business/Industry: INS. COMPANY

17. Father's Name (First, Middle, Last): RAYMOND WERT

18. Mother's Name (First, Middle, Maiden Surname): HILDA JERGENSON

19a. Informant's Name/Relationship (Type, Print): SUSAN THOMPSON (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6800 DOGWOOD RD. BALTO. MD 21207

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): PARKWOOD CEMETERY

Date: 1/26/01

20c. Location - City or Town, State: BALTO. MD

21. Signature of Funeral Service Licensee: Paul M. Stella.

22. Name and Address of Facility: HARTLEY MILLER FUNERAL HOME CHTD. 7527 HARFORD RD. BALTO MD 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Robert E. McCarthy III MD.

29c. License number: D 46300

29d. Date signed (Month, Day, Year): 01/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT E. McCARTHY MD. 5900 Cedar Lane, Columbia, MD 21044

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-0306-510
jhm
STEVEN
JOHANSEN

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01590

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Steven Johansen III
2. Data of Death (Month, Day, Year): JANUARY 18, 2001
3. Time of Death: 20:45 PM
4a. Facility Name *(If not institution, give street and number)*: CENTRAL BOOKING AND INTAKE FACILITY
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-02-4331
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 32 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Feb. 14, 1968
9. Birthplace *(State or Foraign Country)*: MD

Usual Residence of Decedant

10a. State: MD
10b. County: Non-Applicable
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 7519 Rockridge Rd.
10f. Zip Code: 21208
10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1 [ ] Yas 2 [X] No If Yas, Giva Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.): 1 [ ] Yas 2 [X] No *Specify:*
14. Race - Amaricen Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
18a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT usa retired)*: Carpenter
16b. Kind of Business/Industry: Home Improvement

17. Fathar's Nama *(First, Middle, Last)*: Steven Johansen, Jr.
18. Mothar's Name *(First, Middle, Maiden Sumama)*: Linda Johansen

19a. Informant's Name/Ralationship *(Type, Print)*: Mary Lou Johansen, Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3720 College Ave. Ellicott City, MD. 21043

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Othar *(Specify)*
20b. Place of Disposition *(Nama of cematary, cramatory or othar piece)*: Glen Haven Memorial Park
Data: 1-25-01
20c. Location - City or Town, State: Glen Burnie, MD

21. Signature of Funaral Sarvice Licensee: Rebecca Robinson
22. Nama and Address of Facility: Ambrose Funeral Home of Lansdowne, 2719 Hammonds Ferry Rd. Lansdowne, MD. 21227

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the daeth. Do not antar the mode of dying, such as cardiac or raspiratory errest, shock, or haart failura. List only ona causa on aach lina.

Approximeta Interval Between Onsat and Death

Immediata Causa (Final disaasa or condition resulting in daath)
a. HANGING
Dua to (or as a consequence of):
b.
Dua to (or as a consequence of):
c.
Dua to (or as a consequanca of):
d.

Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yas 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was casa rafarred to medical examinar? 1 [X] Yes 2 [ ] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Othar: 4 [ ] Nursing Homa 5 [ ] Residence 8 [X] Other *(Specify)* SCENE

27. Manner of Deeth: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicida 4 [ ] Homicida 5 [ ] Pending Investigetion 6 [ ] Could not be determined
28a. Data of Injury *(Month, Day, Year)*: 1/18/01 FOUND
28b. Time of Injury: 2010 FOUND M
28c. Injury at Work? 1 [ ] Yas 2 [X] No
28d. Describe how injury occurred: SUBJECT HANGED SELF
28a. Place of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*: CENTRAL BOOKING
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: CENTRAL BOOKING AND INTAKE FACILITY, BALTIMORE MD

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Cartifiar *(Check only one)*: 1 [ ] **Certifying Physician**: To tha best of my knowledge, death occurred at tha time, dete and place, and dua to tha causa(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of axamination and/or investigation, in my opinion, daath occurred at the time, dete and place, and due to the cause(s) and mannar statad.

29b. Signature and title of certifier: [signature], M.D.
29c. License number: OCME
29d. Data signed *(Month, Day, Year)*: JANUARY 19, 2001

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print): Mary C. Ripple, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01591

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELLA RUTH JAMES
2. Deta of Death: Month 01 Day 19 Year 2001
3. Time of Death: 5:00p.m.
4a. Facility Name (If not institution, give street and number): Catonsville Nursing Home
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-18-1475
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs.
If Under 1 Yaer: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): 07 29 25
9. Birthplaca (State or Foraign Country): N.C.

Usual Residence of Decedent

10a. Stata: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1XXas 2☐ No
10e. Street and Number: 1641 Poplar Grove Street
10f. Zip Coda: 21216
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Nevar Marriad 2☐ Merried 3☐ Widowed 4XXDivorced
12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yes 3XXNo If Yas, Give Yeer or Detes:
13. Was Decedant of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yes XXNo Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highast grada compleated): Elementary/Secondary (0-12): 12th grade; Collega (1-4or 5+): na
16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): Nursing
16b. Kind of Business/Industry: Private

17. Fathar's Nama (First, Middle, Last): Silas A. Cofield
18. Mothar's Name (First, Middle, Maiden Surnama): Ella G. German

19a. Informant's Name/Reletionship (Type, Print): Wonder Timmons-Son
19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda): 1641 Poplar Grove Street, Baltimore Md 21216

20a. Method of Disposition: XXBurial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or othar place): Arbutus Memorial Park
Data: 1/26/01
20c. Location - City or Town, Stata: Arbutus, Md

21. Signature of Funeral Service Licensee: John B. Johnson Jr.
22. Nama and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that caused the death. Do not entar the moda of dying, such es cardiac or respiratory arrest, shock, or heart lailura. List only ona causa on aach lina.

Approximate Interval Between Onset and Death

Immediata Causa (Final disease or condition resulting in death)
a. CVA — 3/99 yrs.
Dua to (or as a consequance of):
b. HTN
Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Disease or Injury that initiated evants resulting in death) Last
Dua to (or as a consequance of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa ralarred to medical examinar? 1☐ Yes 2☑ No
26. Place of Death (Check only ona): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Othar: 4☑ Nursing Home 5☐ Rasidance 8☐ Othar (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Dascribe how injury occurred
28a. Plece of Injury - At homa, larm, straet, factory, office building, atc. (Specify)
28l. Location (Street and Number or Rural Routa Number, City or Town, Stata)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledga, daath occurred at tha tima, data and place, and dua to the ceuse(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, deeth occurred at the tima, date and place, and due to tha cause(s) and mannar stated.
29b. Signetura and titla of certifier: Attending MD
29c. Licansa number: D36942
29d. Date signed (Month, Day, Year): January 22, 2001
30. Name and address of person who completed causa of death (Item 23a) (Type, Print): B. TURAKHIA, MD 1009, Frederick Rd. Baltimore, MD 21228

State Registrar

31. Data filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01592

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Harold F. Jackson, Sr.

2. Date of Death Month Day Year: January 19, 2001

3. Time of Death: 3:45 PM

4a. Facility Name *(If not institution, give street and number)*: Baltimore VAMC Rehab/Extended Care Ctr.

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-18-5983

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 12, 1920

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Middle River

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 145 Rodeo Circle

10f. Zip Code: 21220

10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: 1944-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 Years; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mill Wright

16b. Kind of Business/Industry: American Can Company

17. Father's Name *(First, Middle, Last)*: Jefferson Davis Jackson

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Jefferson Lay

19a. Informant's Name/Relationship *(Type, Print)*: Pearl A. Jackson, (Wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 145 Rodeo Circle Baltimore, Maryland 21220

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Sacred Ht. of Jesus Cem.

Date: 1/23/2001

20c. Location - City or Town, State: Dundalk, Maryland

21. Signature of Funeral Service Licensee: Teagan E. Read

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Alzheimer's Disease — 5 Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☒Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David Loreck MD

29c. License number: D37070

29d. Date signed *(Month, Day, Year)*: January 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David J. Loreck M.D. Baltimore VAMC Rehab/Extended Care

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001

32. Registrar's Signature: Jeanne G Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 01593

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Young Soo Kim

2. Date of Death — Month: January; Dey: 22; Year: 2001

3. Time of Death: 5:00AM

4a. Facility Neme *(If not institution, give street and number)*: Howard County General Hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 219-76-3042

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 48 Yrs.

If Under 1 Year — Months: ; Deys: ; If Under 24 Hrs. — Hours: ; Min.:

8. Dete of Birth *(Month, Dey, Year)*: Oct. 30, 1952

9. Birthplace *(Stete or Foreign Country)*: Seoul, Korea

Usuel Residence of Decedent

10a. Stete: MD.

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10a. Street and Number: 10429 Kingsbridge Road

10f. Zip Code: 21042

10g. Citizen of What Country?: USA

11. Maritel Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: Asian

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12; College (1-4or 5+):

16a. Decedent's Usuei Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Self-employed

16b. Kind of Business/Industry: Resturant

17. Father's Neme *(First, Middle, Last)*: Ki Sung Kim

18. Mother's Neme *(First, Middle, Meiden Surname)*: Sook Ja Kim

19a. Informent's Neme/Reietionship *(Type, Print)*: Christopher Young Kim-son

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 10429 Kingsbridge Road, Ellicott City, Maryland21042

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or other piece)*: Crestlawn Memorial Gardens 2001 Marriottsville, MD. Dete: 01/24/

20c. Location - City or Town, Stete

21. Signeture of Funerei Service Licensee: [signature]

22. Neme end Address of Feciiity: Witzke Funeral Home, Inc. 1630 Edmondson Avenue, Catonsville, MAryland21228

Physician /Medical Examiner

23a. Part I. Enter the diseesi or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on each line.

Approximate Interiel Between Onset and Death

Immediete Ceuse (Final disease or condition resulting in death)

a. Hepatoma — 1 month

Due to (or es e consequence of):

b. Liver Cirrhosis — 10 yr.

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

Due to (or es a consequence of):

c. Hepatitis B. — 10 yr

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth *(Check only one)*: Hospitel: 1 [ ] Inpetient 2 [X] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury: M

28c. injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and piece, end due to the cause(s) and menner es steted. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted.

29b. Signeture and title of certifier: [signature] MD

29c. License number: D40235

29d. Dete signed *(Month, Day, Year)*: 1/23/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Choon K. Kim 210 Washington Height Westminster MD 21157

State Registrar

31. Dete filed *(Month, Dey, Year)*: JAN 24 2001

32. Registrer's Signature: [signature] ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01594

KIRBY, WALTER

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Walter Warren Kirby
2. Date of Death: Month JANUARY Day 18, Year 2001
3. Time of Death: 12:30 A.M.
4e. Facility Name (If not institution, give street and number): Berlin Nursing & Rehabilitation Center
4b. City, Town, or Location of Death: Berlin
4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 218-14-8443
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 78 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02/06/1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 8238 Silver Run Ct.
10f. Zip Code: 21122
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: 01/1943 - 11/1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Flooring
16b. Kind of Business/Industry: County Government
17. Father's Name (First, Middle, Last): Walter W. Kirby
18. Mother's Name (First, Middle, Maiden Surname): Alice E. Keilholtz
19a. Informant's Name/Relationship (Type, Print): Mary Kathleen Thompson/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 525 Bend Circle Rd. Glen Burnie, Maryland 21061
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Nat'l Mem'l Park — Date: 01/20/01
20c. Location - City or Town, State: Laurel , Maryland
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, Maryland 21227

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Carcinoma of Prostate — 9 mon
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Renal Failure
Dementia -
Hypertension

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D02026
29d. Date signed (Month, Day, Year): Jan-18-01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. FEDERICO ARTHES, 46 TEAL CIRCLE, BERLIN, MD 21811

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: [signature] G Sparks

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01595

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Johe Hill Kiel
2. Date of Death (Month, Day, Year): January 21, 2001
3. Time of Death: 12:05 PM
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Ctr.
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-28-4185
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 6,1935
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7802 St. Boniface Lane
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: Korean
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 Years; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Operating Engineer
16b. Kind of Business/Industry: Heavy Equipment Construction

17. Father's Name (First, Middle, Last): Abner S. Keil
18. Mother's Name (First, Middle, Maiden Surname): Katherine Ketchum

19a. Informant's Name/Relationship (Type, Print): Mrs. Carolyn N. Kiel (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7802 St. Boniface Lane Dundalk, Maryland 21222

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp.
Date: 1/24/2001
20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Dragon E. Reed
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Probable Myocardial Infarction — Minutes

Due to (or as a consequence of): b. Probable arteriosclerotic heart disease — unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: End stage chronic obstructive pulmonary disease
Asbestosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ian K Sleman MD
29c. License number: D33231
29d. Date signed (Month, Day, Year): 01/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type/Print): IAN K SLEMAN MD 8817 Belair Rd. Ste 205, Baltimore MD 21236

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01596

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Winifred C. Koppelman

2. Date of Death Month: January Day: 16 Year: 2001

3. Time of Death: 1145

4a. Facility Name *(If not institution, give street and number)*: Upper Chesapeake Medical Cntr

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 217-22-2186

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: DEC 11, 1928

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md

10b. County: Harford

10c. City, Town or Location: Jarrettsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1338 North Bend Rd.

10f. Zip Code: 21084

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+): —

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Realtor

16b. Kind of Business/Industry: Real Estate

17. Father's Name *(First, Middle, Last)*: Joseph C. Busch

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary B.

19a. Informant's Name/Relationship *(Type, Print)*: Teresa Ayres daug.

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1338 North Bend Rd. Jarrettsville, Md 21084

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Mary's Ch. Cem

Date: Jan 20 2001

20c. Location - City or Town, State: Pylesville Md

21. Signature of Funeral Service Licensee: Krista L. Wells

22. Name and Address of Facility: Evans Funeral Chapel 3 Newport Dr. Forest Hill, Md 21050

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Atherosclerotic coronary artery disease — 5 YEARS

Due to (or as a consequence of):
b. END STAGE RENAL DISEASE — 1 ½ YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. PERIPHERAL ATHEROSCLEROTIC VASCULAR disease

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Elias Khouri MD

29c. License number: D0035706

29d. Date signed *(Month, Day, Year)*: JANUARY, 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Upper Chesapeake Medical Center Bel Air, Maryland

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001

32. Registrar's Signature: Geneva G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Koppelman, Winifred

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01597

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ellen Kelly Kiel

2. Date of Death: Month: January Day: 21 Year: 2001

3. Time of Death: 3:27 A.M.

4a. Facility Name (If not institution, give street and number): Stella Maris

4b. City, Town, or Location of Death: Timonium

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-80-5443

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 02/10/1912

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6117 Deerbrook RD

10f. Zip Code: 21228

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Jerome I. Kelly, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Ellen O'Brien

19a. Informant's Name/Relationship (Type, Print): Ellen Lee Kiel Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 112 English Run Circle Sparks, MD 21152

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): New Cathedral Cemetery

Date: 01/25/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ Robert Shodac

22. Name and Address of Facility: Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Brain Tumor

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Anemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Chris Tyler MD

29c. License number: 055283

29d. Date signed (Month, Day, Year): 1/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Chris Tyler MD 1149 So. Hanover St Baltimore MD 21230

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0240-510
mnmr
Edward Kelley

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01598

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edward Michael Kelley

2. Date of Death Month / Day / Year: January 14, 2001

3. Time of Death: 1604 pm

4a. Facility Name *(If not institution, give street and number)*: 3612 Clipper Road

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 131-22-0540

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 11/ 22/ 1931

9. Birthplace *(State or Foreign Country)*: IL

Usual Residence of Decedent

10a. State: DC

10b. County: N/A

10c. City, Town or Location: Washington

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2517 Pennsylvania Avenue

10f. Zip Code: 20020

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Cement Mason

16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: William H. Kelley

18. Mother's Name *(First, Middle, Maiden Surname)*: Marian O'Donnell

19a. Interment's Name/Relationship *(Type, Print)*: Nancy K. Schneider Sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 40 W. 809 Freeman RD Huntley, IL 60142

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: All Saints Cemetery

Date: 01/20/01

20c. Location - City or Town, State: Des Plaines, IL

21. Signature of Funeral Service Licensee: Stephanie Ahl

22. Name and Address of Facility: Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? Inspection 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* at scene

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. M. Ch for

29c. License number: O.C.M.E.

29d. Date signed *(Month, Day, Year)*: January 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David Fowler, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001

32. Registrar's Signature: Jeanne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01599

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): IRENE LAMP
2. Date of Death (Month, Day, Year): Jan. 21, 2001
3. Time of Death: 5:15AM
4a. Facility Name (If not institution, give street and number): Frederick Villa Nursing Home
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-18-0180
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 24, 1905
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1617 Cole Street
10f. Zip Code: 21223
10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 6 | Cottege (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Barmaid
16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): Howard W. Willing
18. Mother's Name (First, Middle, Maiden Surname): Cora May Girsuch

19a. Informant's Name/Relationship (Type, Print): Irving H. Lamp, Son
19b. Meiting Addresa (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1112 Landington Rd. Baltimore, MD. 21207

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery
Date: 1-25-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Rebecca Robinson
22. Name and Address of Facility: Ambrose Funeral Home 1328 Sulphur Spring Rd. Arbutus, MD. 21227

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. Liat only one ceuse on each tine.

		Approximete Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	CAD	Yrs
Due to (or es e consequence of): b.	Cardiac arrhythmia	Yrs
Sequentially list conditions, If any, leeding to Immediete cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last — Due to (or as a consequence of): c.	HTN	Yrs
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uee contribute to the cauee of death? 1☐ Yee 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No
26. Placa of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residanca 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete and placa, end due to the cause(s) end manner stated.

29b. Signature end title of certifier: B. Tukakhia Covering Attending
29c. License number: D36942
29d. Date signed (Month, Day, Year): January 22, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): B. TUKAKHIA, MD 1009, Frederick RD, Baltimore, MD 21228

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrer's Signature: Geneva G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01600

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Wayne Larkin

2. Date of Death: Month JANUARY Day 20, Year 2001

3. Time of Death: 4:39 PM

4a. Facility Name (If not institution, give street and number): Stella Maris Hospice at Mercy Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-46-5000

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 54 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 23, 1946

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1400 Hull Street

10f. Zip Code: 21230

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager

16b. Kind of Business/Industry: Race Track

17. Father's Name (First, Middle, Last): John E. Larkin

18. Mother's Name (First, Middle, Maiden Surname): Rita C. Schwartz

19a. Informant's Name/Relationship (Type, Print): Glenna Larkin - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1400 Hull Street, Baltimore Maryland 21230

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory Date: January 24, 2001

20c. Location - City or Town, State: Baltimore Maryland

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.

22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue Baltimore Maryland 21230

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Renal Cell Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) Stella Maris at Mercy Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D 40854

29d. Date signed (Month, Day, Year): January 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St Paul Pl Baltimore MD 21202

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

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ORIGINAL

01-0373-005
jhm
TODD
LEVY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS # 23a,27,28a-f per M.E. G792 020101 SS **Certificate of Death** Reg. No. 2001 01601

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Todd Levy
2. Date of Death Month/Day/Year: JANUARY 23, 2001
3. Time of Death: 01:23 AM
4a. Facility Name *(If not Institution, give street and number)*: 5 WENSLEY DALE COURT
4b. City, Town, or Location of Death: OWINGS MILLS
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 214-23-2380
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 24 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 06- 1976
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Owings Mills
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 5 Wensley Dale Court
10f. Zip Code: 21117
10g. Citizen of What Country?: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 3
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: college student
16b. Kind of Business/Industry: college

17. Father's Name *(First, Middle, Last)*: H. Peter Levy
18. Mother's Name *(First, Middle, Maiden Surname)*: Ellen Horowitz Orlinsky

19a. Informant's Name/Relationship *(Type, Print)*: H. Peter Levy-father
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11021 Woodelves Way, Columbia, Maryland 21044

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Columbia Memorial Park
Date: 01/24/2001
20c. Location - City or Town, State: Clarksville, Maryland

21. Signature of Funeral Service Licensee: Bernard Dalinsky
22. Name and Address of Facility: Witzke Funeral Home , Inc. 5555 Twin Knolls Road, Columbia, Maryland21045

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. NARCOTIC INTOXICATION
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No
24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No
26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other *(Specify)* SCENE

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined
28a. Date of Injury *(Month, Day, Year)*: FOUND: 1/23/01
28b. Time of Injury: 1:23 a^M
28c. Injury at Work? 1☐Yes 2☒No
28d. Describe how injury occurred: UNKNOWN
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: RESIDENCE
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 5 Wensley Dale Owings Mills, MD

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore M. King MD
29c. License number: OCME
29d. Date signed *(Month, Day, Year)*: JANUARY 23, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001
32. Registrar's Signature: Deputy D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01602

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SYLVIA LEVINSON

2. Date of Death Month / Day / Year: JANUARY 7, 2001

3. Time of Death: 4:50 AM

4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-14-6059

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: FEB 23, 1919

9. Birthplace *(State or Foreign Country)*: WASHINGTON, DC

Usual Residence of Decedent

10a. State: MD

10b. County: MONTGOMERY

10c. City, Town or Location: SILVER SPRING

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 614 UNIVERSITY BLVD. WEST

10f. Zip Code: 20901

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify*: WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: SAMUEL DUNAYER

18. Mother's Name *(First, Middle, Maiden Surname)*: JENNY "UNAVAILABLE"

19a. Informant's Name/Relationship *(Type, Print)*: SHARYN DORFMAN/DAUGHTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 17724 STONERIDGE DRIVE, GAITHERSBURG, MARYLAND 20878

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: KING DAVID MEMORIAL GDNS

Date: JAN 10, 2001

20c. Location - City or Town, State: FALLS CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart leilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death)

a. CORONARY HEART DISEASE — 6 MONTHS

Due to (or as a consequence of):

b. RESPIRATORY FAILURE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. OGILIVIRS SYNDROME

Due to (or as a consequence of):

d. HYPOTHYROIDISM

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinton, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D 28656

29d. Date signed *(Month, Day, Year)*: JANUARY 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAVI PASSI, MD 15225 SHADY GROVE ROAD #208, ROCKVILLE, MARYLAND 20850

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01603

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BETTY JANE LANG
2. Date of Death (Month, Day, Year): January 21, 2001
3. Time of Death: 2:40 AM
4a. Facility Name (If not institution, give street and number): 520 Portia's Delight Dr.
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 219-10-2442
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 13, 1925
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 520 Portia's Delight Dr.
10f. Zip Code: 21158
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Receptionist
16b. Kind of Business/Industry: Salon

17. Father's Name (First, Middle, Last): Harry Elmer Jackson
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Cornelia Smith

19a. Informant's Name/Relationship (Type, Print): Mr. Harry J. Lang/husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 520 Portia's Delight Dr. Westminster, Md. 21158

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Thomas Epis. Church
Date: 1/24/01
20c. Location - City or Town, State: Owings Mills, Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Metastatic Colon Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Lung Cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D33576
29d. Date signed (Month, Day, Year): 1/28/01
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 01604

AMEND#5 PER F.H. G792 2-6-2001 JAB

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FLORENCE MILDENBERGER
2. Date of Death (Month, Day, Year): Jan. 22, 2001
3. Time of Death: 7:00AM
4a. Facility Name (If not institution, give street and number): 5624 Huntsmoore Rd.
4b. City, Town, or Location of Death: Halethorpe
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 050-01-~~4430~~ 3190
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 7, 1916
9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Halethorpe
10d. Inside City Limits: 1☐ Yes 2☒ No XX
10e. Street and Number: 5624 Huntsmoore Rd.
10f. Zip Code: 21227
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Emmette Lewis Rich
18. Mother's Name (First, Middle, Maiden Surname): Winifred Poppel

19a. Informent's Neme/Relationship (Type, Print): Debra Mathews, Daughter
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 126 Maiden Choice Lane Catonsville, MD. 21228

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Metro Crematory
Date: 1-25-01
20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funeral Service Licensee: ▶ Rebecca Robinson
22. Name end Address of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert felture. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction
Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypothyroidism
Degeneration joint disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was case referred to medicet examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Phyaician:** To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture and title of certifier: ▶ Karkaran
29c. License number: D21649
29d. Date signed (Month, Day, Year): JAN 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAMBANDAM BASKARAN, 3455 Wilkens Ave. BALTIMORE, MD 21229

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signeture: ▶ G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01605

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John Wyeth Myers

2. Date of Death Month Day Year: Jan. 15, 2001

3. Time of Death: 1:16 pm

4a Facility Name *(If not institution, give street and number)*: John Hopkins Bayview Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-44-5917

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 57 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: July 14, 1943

9. Birthplace *(State or Foraign Country)*: MD

Usual Rasidence of Decedent

10a. Stata: MD

10b. County: Baltimore

10c. City, Town or Location: Lansdowne

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 226 Hazel Ave.

10f. Zip Code: 21227

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Nevar Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completad)*: Elementery/Secondery (0-12): 8 | Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working lifa. DO NOT usa ratired)*: Subcontracting

16b. Kind of Businass/Industry: B.A.R.C.

17. Fathar's Nama *(First, Middla, Last)*: Albert Gillette Myers, Sr.

18. Mother's Name *(First, Middle, Maiden Sumama)*: Mary Elizabeth Dobson

19a. Informant's Name/Ralationship *(Type, Print)*: Walter Robert Myers, brother

19b. Mailing Addrass *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 226 Hazel Ave. Lansdowne, MD. 21227

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramovat from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cemetary, cramatory or othar placa)*: New Cathedral Cemetery

Data: 1-18-01

20c. Location - City or Town, Stata: Baltimore, MD

21. Signafura of Funaral Sarvice Licensee: Rebecca Robinson

22. Nama and Addrass of Facility: Ambrose Funeral Home of Lansdowne, 2719 Hammonds Ferry Rd. Lansdowne, MD. 21227

Physician /Medical Examiner

23a. Part1. Entar the disaase, or complications thet caused tha daath. Do not entar tha moda of dying, such es cardiec or respiretory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximate Intarval Batween Onsat and Death

Immediata Causa (Final disaasa or condition resulting in daath)

a. Acute Pulmonary Edema — Hours.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Diseasa or injury that initiated events resulting in death) Last

b. Generalized Atherosclerotic Cardiovascular Dis — 10 Yrs

Due to (or as a consequence of):

c. with ESRD Stage 5 Renal Dysfunction on — 7 Yrs

Due to (or as a consequence of):

d. Down's Syndrome with Mental Retardation — Since Birth

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

Recent Bilateral Pneumonia

History of Seizure Disorder

23b. Did tobacco use contribute to the cause of death? 1☐ Yas 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Wes case rafarred to medicat exeminer? 1☐ Yas 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA | Othar: 4☐ Nursing Homa 5☐ Rasidence 6☐ Othar *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at tha tima, data and piece, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: Michael A Hyke MD

29c. Licensa number: D27693

29d. Data signed *(Month, Day, Year)*: 1/18/2001

30. Nama and address of person who compiated causa of death (Item 23a) (Type, Print): Michael A Hyke MD; 6530 Walther Ave Baltimore, md 21206

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 24 2001

32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.: 2001 01606

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alice ELIZABETH McIver

2. Date of Death (Month, Day, Year): JANUARY 23 2001

3. Time of Death: 1:40 PM

4a. Facility Name (If not institution, give street and number): Saint Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 423-32-0112

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 1, 1913

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Md.

10b. County: Balto.

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1315 Highland Drive

10f. Zip Code: 21239

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cook

16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): Walter Cross

18. Mother's Neme (First, Middle, Meiden Surneme): Bertha Murchison

19a. Informant's Name/Relationship (Type, Print): Shirley Viola Carr

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1315 Highland Drive Towson, Md. 21239

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): New Hope Church Cem

Date: Jan 29 2001

20c. Location - City or Town, State: Sanford, N.C.

21. Signature of Funeral Service Licensee: Carlton C. Douglass

22. Name and Address of Facility: Carlton C. Douglass Funeral Service P.A. 1701 McCulloh St. Balto. Md. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heert feilure. List only one ceuse on each line.

Approximete Interval Between Onset end Death

Immediate Ceuse (Finel disease or condition resulting in death): a. ANOXIC ENCEPHALOPATHY

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other atgnificant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the causa of death? 1☐ Yaa 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and mennar es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: Francis Khoo

29c. License number: D 30263

29d. Dete signed (Month, Dey, Year): 1-23-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANCIS KHOO, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204

State Registrar

31. Date filed (Month, Dey, Year): JAN 24 2001

32. Registrer's Signeture: Teresa D. Coates

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ADH
01-0335-510
BETTY MCKNIGHT

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01607

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Betty McKnight
2. Date of Death (Month, Day, Year): JANUARY 20, 2001
3. Time of Death: 1405 PM
4a. Facility Name (If not institution, give street and number): 401 EAST 25TH STREET
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: NA

Funeral Director

5. Social Security Number: 247-64-7298
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 62 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-29-38
9. Birthplace (State or Foreign Country): SC

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 401 East 25th Street
10f. Zip Code: 21218
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th Grade
College (1-4or 5+): 2yrs.
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse
16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): John S. Watkins
18. Mother's Name (First, Middle, Maiden Surname): Vergie Gaffney

19a. Informant's Name/Relationship (Type, Print): Ronald Watkins
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 304 Shellnut Avenue Columbia, S.C. 29209

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Sinai Bapt. Ch.
Date: Cem. 01-28-01
20c. Location - City or Town, State: Gaffney, SC

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Baltimore, Maryland 21202
WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hypertensive Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? INSPECTION 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) AT SCENE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Theodore M. King MD
29c. License number: OCME
29d. Date signed (Month, Day, Year): JANUARY 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Theodore M. King 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 01608

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGARET A. MILLER

2. Date of Death (Month, Day, Year): JAN. 16, 2001

3. Time of Death: 9:10PM

4a. Facility Name (If not institution, give street and number): JOSEPH RITCHIE HOSPICE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-07-8846D

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV. 12, 1915

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.

10b. County: BALTIMORE

10c. City, Town or Location: DUNDALK

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1205 S. 48TH STREET

10f. Zip Code: 21222

10g. Citizen of What Country: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): GEORGE BRENDEL

18. Mother's Name (First, Middle, Maiden Surname): ROSE NAPRASKI

19a. Informant's Name/Relationship (Type, Print): ROSE KRAEGER/SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1511 ELRINO ST., BALTIMORE, MD. 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): SACRED HEART OF JESUS

Date: 1/19/01

20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: Robert J. Lemmon #00521

22. Name and Address of Facility: CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MD. 21224

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Congestive Heart Failure — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☑ Other (Specify) Hospice

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Francis X. Strain III MD

29c. License number: D44715

29d. Date signed (Month, Day, Year): 1-17-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANCIS X. STRAIN, III MD 301 ST PAUL # 907

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signature: Linda D. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

9:10 pm 1-16-01 MARGARET MILLER

DHMH 16 Rev 6/95

ORIGINAL

01-0307-005
ELIZABETH A. MAJKA
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01609

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELISABETH ANNE MAJKA-ROSE

2. Date of Death: Month JANUARY Day 19 Year 2001

3. Time of Death: 0344

4a. Facility Name (If not institution, give street and number): REISTERTOWN RD. & GENTLEBROOK

4b. City, Town, or Location of Death: REISTERTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 213-68-9049

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 30 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 24, 1970

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.

10b. County: BALTIMORE

10c. City, Town or Location: GWYNN OAKS

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 4116 VILLA NOVA RD.

10f. Zip Code: 21207

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12TH

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PROGRAM DIRECTOR

16b. Kind of Business/Industry: WOMANS HOUSING COALITION

17. Father's Name (First, Middle, Last): EDWARD MAJKA

18. Mother's Name (First, Middle, Maiden Surname): SHARON E. MAJKA

19a. Informant's Name/Relationship (Type, Print): EDWARD MAJKA/FATHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20 SHEFFIELD DRIVE, DILLSBURG, PA.17019

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ST. STANISLAUS CEM.

Date: 1/23/01

20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: Richard J. Stewart MD0534

22. Name and Address of Facility: CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MD. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MULTIPLE INJURIES

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) SCENE

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year): 1/19/01 FOUND

28b. Time of Injury: FOUND 0323 M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: DRIVER OF CAR WHICH STRUCK A FIXED OBJECT

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): MAJOR STREET

28f. Location (Street and Number or Rural Route Number, City or Town, State): REISTERSTOWN ROAD AND GENTLEBROOK, REISTERSTOWN, MD

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. License number: O.C.M.E

29d. Date signed (Month, Day, Year): JANUARY 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signature: Denise B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01610

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MATTIE ELIZABETH MILLER
2. Date of Death (Month, Day, Year): JANUARY, 22, 2001
3. Time of Death: 10:30 AM

4a. Facility Name (If not institution, give street and number): FUTURE CARE NURSING HOME
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 215-22-6830
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MARCH 12, 1924
9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: -
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6543 HILLTOP AVE.
10f. Zip Code: 21206
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12YRS. College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SUPERVISOR
16b. Kind of Business/Industry: BENDIX

17. Father's Name (First, Middle, Last): ALBERT BATTON
18. Mother's Name (First, Middle, Maiden Surname): HATTIE FULLER

19a. Informant's Name/Relationship (Type, Print): JANICE E. CARTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6543 HILLTOP AVE BALTIMORE, MARYLAND 21206

20a. Method of Disposition: ☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GARDENS OF FAITH — Date: JAN. 25, 2001
20c. Location - City or Town, State: ROSEDALE, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD PARKVILLE, MARYLAND 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	END STAGE RENAL DISEASE	TWO YEARS
Due to (or as a consequence of): b.	TYPE II DIABETES MELLITUS	50 YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ESSENTIAL HYPERTENSION
CORONARY ARTERY DISEASE
HYPOTHYROIDISM

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year):
28b. Time of Injury: — M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred:
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):
28f. Location (Street and Number or Rural Route Number, City or Town, State):

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Komal K. Dang M.D.
29c. License number: D18362
29d. Date signed (Month, Day, Year): January, 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KOMAL K. DANG M.D. 3455, Wilkens Ave Suite 308 · BALTO · MD 21229

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

NAME

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01611

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Leslie Napier

2. Date of Death Month / Day / Year: 1 - 19 - 01

3. Time of Death: 12 45

4a. Facility Name *(If not institution, give street and number)*: Genesis Randallstown Center

4b. City, Town, or Location of Death: Baltimore, Md

4c. County of Death: Randallstown

Funeral Director

5. Social Security Number: 255-44-1629

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 04 15 30

9. Birthplace *(State or Foreign Country)*: G.A.

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Randallstown

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3604 Annie Hathaway Drive Apt 1D

10f. Zip Code: 21133

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th grade; College (1-4or 5+): na

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Steel Worker

16b. Kind of Business/Industry: Allied Signal

17. Father's Name *(First, Middle, Last)*: Leslie M. Napier Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Essimay Ward

19a. Informant's Name/Relationship *(Type, Print)*: Yveatte Pratt-Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2721 Water Wheel Ct. Ellicott City, Md 21043

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Garrison Forest Vet.

Date: 1/25/01

20c. Location - City or Town, State: Owings Mills, Md

21. Signature of Funeral Service Licensee: John B. Johnson

22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC CARDIOVASCULAR DIS — YRS

Due to (or as a consequence of):

b. HYPERTENSION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PULMONARY HYPERTENSION, NON-SUSTAINED VENTRICULAR TACHYCARDIA, RENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: K. Zonies MD

29c. License number: D20333

29d. Date signed *(Month, Day, Year)*: 1/22/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K. ZONIES MD 1838 ALLENTOWN RD PIKESVILLE, 21208

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS #7 & 8 per fh G791 012401 SS

Certificate of Death

Reg. No. 2001 01612

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Clifton O'Connell

2. Dete of Death — Month: January; Dey: 21; Year: 2001

3. Time of Death: 0505

4a. Facility Name (If not institution, give street and number): Johns Hopkins

4b. City, Town, or Location of Death: Baltimore

4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 212-46-3720

6. Sex: 1☐ M 2☐ F — X

7. Age (In yrs. last birthday): 54 Yrs.

If Under 1 Yeer — Months: ; Deys:

If Under 24 Hrs. — Hours: ; Min.:

8. Dete of Birth (Month, Dey, Year): July 15, 1946

9. Birthplace (State or Foreign Country): MD

Usuel Residence of Decedent

10a. Stete: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes X☒ No

10e. Street and Number: 800 Maiden Choice Lane

10f. Zip Code: 21228

10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced — X

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — X — If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No — X — Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Eduestion (Specify only highest grede completed) — Elementary/Secondery (0-12): 12; College (1-4or 5+): 5

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Steam Fitter

16b. Kind of Business/Industry: Industrial

17. Fether's Neme (First, Middle, Last): William F. O'Connell

18. Mother's Neme (First, Middle, Maiden Surname): Viola M. Henry

19a. Informent's Name/Reletionship (Type, Print): Tierney O'Connell, daughter

19b. Meiling Address (Streat and Number or Rural Route Number, City or Town, Stete, Zip Code): 800 Maiden Choice Lane Catonsville, MD. 21228

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify) — X

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Metro Crematory

Dete: 1-22-01

20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funeral Service Licensee: Jan Le Judice

22. Neme end Address of Feeility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused tha deeth. Do not enter the mode of dying, such es cardiac or respiratory arrast, shock, or heart failura. List only one ceuse on eech line.

Approximete Interval Between Onset and Deeth

Immediete Ceuse (Finel diseese or condition resulting in death)

a. Hypotension — 2 days

Due to (or as e consequance of):

b. Endstage liver disease — 5 years

Sequentiellly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Causa (Disease or Injury thet Initiated events resulting in deeth) Last

Due to (or es a consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significant conditione** contributing to death but not resulting in the underlying ceuse given in Part I.

Hepatic Encephalopathy, Renal Failure, Methicillin-resistant Staphylococcus aureus, Massive upper gastrointestinal bleed

23b. Did tobacco use contributs to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveileble prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one) — Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete end piece, end due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) and menner steted.

29b. Signeture end title of certifier: Ian Brown

29c. License number: RES-000

29d. Dete signed (Month, Dey, Year): January 21, 2001

30. Name and address of person who completed ceusa of deeth (Item 23a) (Type, Print): Ian Brown 600 North Wolfe Street Baltimore MD

State Registrar

31. Dete filed (Month, Dey, Year): JAN 24 2001

32. Registrer's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01613

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOSEPH ORACKI
2. Date of Death Month / Day / Year: JANUARY 19 2001
3. Time of Death: 4:53 am
4a. Facility Name *(If not institution, give street and number)*: THE JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death:

Funeral Director

5. Social Security Number: 215-09-9410
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 9/10/1920
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 3502 E. Northern Parkway
10f. Zip Code: 21206
10g. Citizen of Whet Country?: U.S.A.

11. Meritel Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sorter
16b. Kind of Business/Industry: Post Office

17. Father's Neme *(First, Middle, Last)*: Adam Oracki
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Clara Jacobowski

19a. Informent's Neme/Reletionship *(Type, Print)*: Clara Oracki/Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 3502 E. Northern Parkway Baltimore, Maryland 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Plece of Disposition *(Name of cemetery, crematory or other place)*: Gardens of Faith Cemetery | Dete: 1/22/01
20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funeral Service Licensee:
22. Neme and Address of Feclility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximate Interval Between Onset and Deeth

Immediete Ceuse (Finat diseese or condition resulting in death)
a. CARDIAC SURGERY — THREE DAYS
Due to (or es a consequence of):
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest
b. AORTIC STENOSIS — FIFTEEN YEARS
Due to (or es a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No
26. Place of Deeth *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medicat Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: MD
29c. License number: RES 000
29d. Date signed *(Month, Day, Year)*: JANUARY 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. PIROOZ EGHTESADY 600 NORTH WOLFE STREET BALTIMORE, MARYLAND 21287

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 24 2001
32. Registrar's Signeture: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01614

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARIE E. O'CONNOR

2. Date of Death (Month, Day, Year): JANUARY 20, 2001

3. Time of Death: 6:54 AM

4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-18-8386

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 2 1918

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1651 East Belvedere Ave. APT 306

10f. Zip Code: 21239

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse

16b. Kind of Business/Industry: Good Samaritan Hospital

17. Father's Name (First, Middle, Last): Frank Deppisch

18. Mother's Name (First, Middle, Maiden Surname): Margaret Wehner

19a. Informant's Name/Relationship (Type, Print): Karran Chaney Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1817 Cromwood RD Baltimore, MD 21234

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Balto-Wash. Crematory

Date: 01-22-01

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: ▶ Robert Bradley

22. Name and Address of Facility: Bradley Ashton Matthews Funeral Home, Inc. 2134 Willow Springs RD Baltimore, MD 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ASPIRATION PNEUMONIA — 3 DAYS

Due to (or as a consequence of):
b. ACUTE RENAL INSUFFICIENCY — 3 WEEKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. SEVERE CHRONIC CONGESTIVE HEART FAILURE

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
PROGRESSIVE LYMPHOMA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Kofi A. Appiah, MD, Resident Physician

29c. License number: P13450

29d. Date signed (Month, Day, Year): JANUARY 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KOFI A. APPIAH, GOOD SAMARITAN HOSPITAL, BALTIMORE, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01615

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Russell Lee Pryor, Jr.

2. Date of Death: Month January Day 5, Year 2001

3. Time of Death: 8:19 PM

4a. Facility Name (If not institution, give street and number): Harbor Hospital Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-30-7715

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 65 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 11, 1935

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 2834 Ganley Drive

10f. Zip Code: 21230

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No. If Yes, Give Year or Dates: 1953-57

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Fireman

16b. Kind of Business/Industry: Baltimore County

17. Father's Name (First, Middle, Last): Russell Lee Pryor, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Rhonda Jahnigan

19a. Informant's Name/Relationship (Type, Print): Pat Pryor - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2834 Ganley Drive, Baltimore, Md. 21230

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Crownsville Veterans Cem. Date: 1/10/01

20c. Location - City or Town, State: Crownsville, Maryland

21. Signature of Funeral Service Licensee: John Peters

22. Name and Address of Facility: Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Congestive Heart failure	1/2000
Due to (or as a consequence of): b.	Ischemic Cardiomyopathy	1992
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Non Insulin Dependent Diabetes

Acute and Chronic Renal failure

Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D31144

29d. Date signed (Month, Day, Year): 1/08/2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Geriatric Center Fisher P.A. 1600 Crain Hwy SW # 208 Glen Burnie MD. 21061

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signature: Grace D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

2001 01616

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): THERESA M. PASQUALONE			2. DATE OF DEATH: MONTH 1 DAY 19 YEAR 01	3. TIME OF DEATH: 9:10AM	
4. SOCIAL SECURITY NUMBER: 212-03-7966	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 95 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 9-13-05	8. BIRTHPLACE (State or Foreign Country): MARYLAND	
9a. FACILITY NAME (If not institution, give street and number): Rock Spring Village 1 Colgate Drive		9b. CITY, TOWN OR LOCATION OF DEATH: Forest Hill		9c. COUNTY OF DEATH: Harford	
RESIDENCE OF DECEDENT					
10a. STATE: MD	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Forest Hill		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: 1 Colgate Drive		10f. ZIP CODE: 21050		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: U.S.A.	
15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Factory		16b. KIND OF BUSINESS/INDUSTRY: Holland Manufactor	
17. FATHER'S NAME (First, Middle, Last): Libero Pasqualone		18. MOTHER'S NAME (First, Middle, Maiden Surname): Carmelo Mastropaolo			
19a. INFORMANT'S NAME (Type/Print): Michael Lagnese		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3900 Foster Avenue Baltimore, Maryland 21224			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): Holy Redeemer Cemetery	DATE: 1/22/01	20c. LOCATION — City or Town, State: Baltimore, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Martin J. Dippold		22. NAME AND ADDRESS OF FACILITY: John C. Miller Inc. 6415 Belair Road Baltimore, Marylane 21206			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. progressive dementia DUE TO (OR AS A CONSEQUENCE OF):	12 years
Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. OUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Failure

Anemia

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, strael, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: David S. Dunn	29c. LICENSE NUMBER: D32257	29d. DATE SIGNED (Month, Day, Year): ▶ JANUARY 19, 2001
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DAVID S. DUNN 615 W. MACPHAIL		
31. DATE FILED (Month, Day, Year): JAN 24 2001	32. REGISTRAR'S SIGNATURE: Geneva G. Sparks	

DHMN-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01617

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DORIS PINSKY
2. Date of Death: Month JAN Day 20 Year 2001
3. Time of Death: 5:10AM
4a. Facility Name *(If not institution, give street and number)*: VANTAGE HOUSE
4b. City, Town, or Location of Death: COLUMBIA
4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 159-10-3989
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MAY 22 1910
9. Birthplace *(State or Foreign Country)*: ENGLAND

Usual Residence of Decedant

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2807 QUARRY HEIGHTS WAY
10f. Zip Code: 21209
10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yeer or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxicen, Puarto Rican, etc.) 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Black, Whita, atc. *Specify:* WHITE

15. Decedant's Education *(Specify only highast grada compliated)*: Elementery/Secondery (0-12): 12 | Collega (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT use retired)*: PROPRIETOR
16b. Kind of Business/Industry: DRY GOODS

17. Father's Neme *(First, Middle, Last)*: PHILIP BINDERMAN
18. Mother's Nama *(First, Middle, Maiden Surname)*: REBECCA RICE

19a. Informant's Name/Ralationship *(Type, Print)*: SYLVAN PINSKY/SON
19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 2807 QUARRY HEIGHTS WAY BALTIMORE, MD. 21209

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☒ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Nama of Cemetary, crematory, or other place)*: ROOSEVELT MEMORIAL PARK
Data: 1/22/01
20c. Location - City or Town, Stata: TREVOSE, PA.

21. Signature of Funaral Service Licensee: Scott M. Cuttler
22. Name and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complicetions that ceused tha daath. Do not anter tha moda of dying, such as cerdiac or respiretory errest, shock, or heart failura. List only ona causa on each lina.

Approximate Interval Between Onset and Death

Immediete Ceuse (Finei diseasa or condition resulting in daath)
e. END STAGE DEMENTIA — yrs
Dua to (or es e consequence of):
Sequentially list conditions, if any, laeding to immadiata ceuse. Entar Underlying Causa (Diseesa or injury that initiated evants rasulting in death) Last
b. COMMUNITY ACQUIRED PNEUMONIA — yrs
Dua to (or es e consequence of):
c.
Due to (or es a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yas 2☒ No
24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was cese refarred to medicel examiner? 1☐ Yas 2☒ No
26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Homa 5☐ Residence 8☐ Othar *(Specify)*
27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined
28a. Data of Injury *(Month, Dey Year)* | 28b. Tima of Injury | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Dascribe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)* | 28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and piece, and dua to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the ceuse(s) and mannar steted.
29b. Signatura and title of certifier: Steven M. Bloom
29c. Licansa number: D-34868
29d. Data signed *(Month, Day, Year)*: JAN 20, 2001

30. Nama and addrass of person who complated ceusa of daath (Item 23a) (Type, Print): SDIGEN 11055 LITTLE PATUXENT PKWY Columbia, MD 21044

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 24 2001
32. Registrar's Signatura: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01618

Petrucci, Angela
Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Angela Petrucci
2. Date of Death (Month, Day, Year): January 20, 2001
3. Time of Death: 11:10 AM
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-98-3599
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 43 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2-3-57
9. Birthplace (State or Foreign Country): Italy

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Rosedale
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1506 Chesaco Avenue
10f. Zip Code: 21237
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home Maker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Pasquale Perna
18. Mother's Name (First, Middle, Maiden Surname): Maria (Unknown)

19a. Informant's Name/Relationship (Type, Print): Enrico Petrucci/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1506 Chesaco Avenue Baltimore, MD 21237

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): OakLawn Cemetery
Date: 1-23-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Baltimore, MD 21237

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Small Cell Lung Cancer — 4 mos
Due to (or as a consequence of):
b. Acute Respiratory Failure — 48 hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. KETOACIDOSIS — 7 days
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D3355
29d. Date signed (Month, Day, Year): Jan 20, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Huebach 5006 Franklin Sq. 21237

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature:

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01619

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Arthur Reese

2. Date of Death: Month: January Day: 22 Year: 2001

3. Time of Death: 18:20

4a. Facility Name (If not institution, give street and number): St.Agnes Hospital

4b. City, Town, or Location of Death: BAltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 212-09-8810

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 6, 1911

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: —

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 719 Maiden Choice Lane

10f. Zip Code: 21228

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk

16b. Kind of Business/Industry: Insurance

17. Father's Name (First, Middle, Last): Jesse Reese

18. Mother's Name (First, Middle, Maiden Surname): Cecelia M. Murk

19a. Informant's Name/Relationship (Type, Print): Ethel C.Reese- wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 719 Maiden Choice Lane-HR 521, Baltimore, Maryland

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): New Cathedral Cemetery

Date: 01/25/2001

20c. Location - City or Town, State: Baltimore, MD.

21. Signature of Funeral Service Licensee: Bernard Witzke

22. Name and Address of Facility: Witzke Funeral Home, Inc. 1630 Edmondson Avenue, Catonsville, Maryland21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumania — 3 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. chronic lymphocytic leukemia/lymphoma — 5 years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D40850

29d. Date signed (Month, Day, Year): January 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): YVONNE OTTAVIANO MD 900 CATON AVE BALTIMORE MD 21227

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signature: Lewis B. Sparks

FEB 05 2001

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Reese, John A

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.: 2001 01620

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Sister Jean Marie Rogers, OSP
2. Date of Death Month Day Year: 01-22-01
3. Time of Death: 11:10p.m.
4a. Facility Name *(If not institution, give street and number)*: Oblate Sisters of Providence (HCU)
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-60-8227
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 92 Yrs. | If Under 1 Yeer: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 08-04-08
9. Birthplece *(Stete or Foreign Country)*: MD

Usual Residence of Decedent

10a. Stete: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore (Catonsville)
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 701 Gun Road
10f. Zip Code: 21227-3899
10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, apecify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Reca - American Indian, Bleck, White, etc. *Specify:* African-Am.

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): BS
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher
18b. Kind of Business/Industry: School

17. Father's Name *(First, Middle, Last)*: Clarence Rogers
18. Mother'a Neme *(First, Middle, Maiden Sumame)*: Ruth E. Robinson

19a. Informent's Neme/Relationship *(Type, Print)*: Sister M. Alexis Fisher, OSP
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 701 Gun Road Baltimore, MD 21227-3899

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Placa of Disposition *(Nama of cametary, crametory or other piece)*: Loudon Park Cemetery
Deta: 1-25-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funarei Service Licensee: Jerome H. Thompson
22. Name end Address of Facility: March Funeral Home 4300 Wabash Avenue Baltimore, MD 21215

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediete Cause (Final diseasa or condition resulting in death): a. Dehydration — 3 day
Due to (or as a consequanca of):
b. Dementia — 1yr
Due to (or es e consequence of):
Sequentiaily list conditions, if any, leeding to immedieta cause. Enter Underlying Cause (Disaese or injury that initiated evants resulting in death) Lest
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be datarmined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, atreet, fectory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To tha best of my knowledga, daath occurred at the time, date and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examnetion end/or investigation, in my opinion, daath occurred at the tima, data and place, and dua to the causa(s) end menner steted.

29b. Signeture and title of certifier: Baskaran
29c. License number: D21649
29d. Deta signed *(Month, Dey, Year)*: Jan 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAMBANDAM BASKARAN. 3455 Wilkens Av. Baltimore. MD 21229

State Registrar

31. Dete filed *(Month, Dey, Year)*: JAN 24 2001
32. Registrer's Signeture: Geneva G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01621

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ETHEL RICHARDSON
2. Date of Death (Month, Day, Year): January 22 2001
3. Time of Death: 4:20pm
4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 217-22-2988
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 05-11-09
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2831 Montebello Terrace
10f. Zip Code: 21214
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 9th Grade; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic
16b. Kind of Business/Industry: in home

17. Father's Name (First, Middle, Last): Robert Newton
18. Mother's Name (First, Middle, Meiden Surname): Irene Rhodes

19a. Informant's Name/Relationship (Type, Print): Ella Parrier
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1412 Linwood Avenue Baltimore, Maryland 21213

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donelion 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Arbutus Mem.Pk. Cem.
Date: 01-26-2001
20c. Location - City or Town, State: Arbutus, MD

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Baltimore, Maryalnd 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediete Cause (Finel disease or condition resulting in death)
a. Septic shock
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: End stage renal disease, COPD, CHF

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: P 13453
29d. Date signed (Month, Day, Year): January 22 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gonzalo Gianella MD. Loch Raven Raven Blvd 5601

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01622

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen Rampata
2. Date of Death Month Day Year: January 20, 2001
3. Time of Death: 9:40 AM
4a. Facility Name *(If not institution, give street and number)*: Stella Maris Hospice
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 166-14-4532
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Apr 17, 1912
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 203 Glyndon Drive
10f. Zip Code: 21136
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Seamstress & Housewife
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Frank Hrenkl
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Mandel

19a. Informant's Name/Relationship *(Type, Print)*: Walter J. Rampata Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 203 Glyndon Drive Reisterstown, MD 21136

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MD State Veterans Cem.
Date: 1/24/01
20c. Location - City or Town, State: Garrison, Maryland

21. Signature of Funeral Service Licensee: Randall B. Eline
22. Name and Address of Facility: Eline Funeral Home 11824 Reisterstown Road Reisterstown, MD 21136

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. LUNG CANCER
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28l. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D43725
29d. Date signed *(Month, Day, Year)*: 1/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

JANUARY 20, 2001 9:40 a.m.

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

HELEN RAMPATA

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01623

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Cecelia Mary Silseth

2. Date of Death Month Day Year: January 23, 2001

3. Time of Death: 8:18am

4a. Facility Name *(If not institution, give street and number)*: St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 502-05-4311

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 21, 1920

9. Birthplace *(State or Foreign Country)*: Minnesota

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Arbutus

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1317 Poplar Ave.

10f. Zip Code: 21227

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Programer

16b. Kind of Business/Industry: SSI

17. Father's Name *(First, Middle, Last)*: Clarence Lee

18. Mother's Name *(First, Middle, Maiden Surname)*: Ellen Mary Weatherhead

19a. Interment's Name/Relationship *(Type, Print)*: Robert Silseth, Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1156 Elm Rd. Arbutus, MD. 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Loudon Park Cemetery

Date: 1-26-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Rebecca Robinson

22. Name and Address of Facility: Ambrose Funeral Home 1328 Sulphur Spring Rd. Arbutus, MD. 21227

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Attending Physician

29c. License number: D51853

29d. Date signed *(Month, Day, Year)*: January 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael A. Silverman, MD 900 Caton Avenue Baltimore 21229

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Cecelia Silseth

10/24

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01624

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ALBERT L SNYDER
2. Date of Death Month / Day / Year: JAN. 23, 2001
3. Time of Death: 5:05 PM
4a. Facility Name *(If not institution, give street and number)*: Eastpoint Nursing Home
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-16-0256
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Mar. 21, 1922
9. Birthplace *(State or Foreign Country)*: Pa.

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 45 Portship Rd.
10f. Zip Code: 21222
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12yrs | College (1-4or 5+): 4 yrs.
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Machinist
16b. Kind of Business/Industry: Steel

17. Father's Name *(First, Middle, Last)*: Raymond Snyder
18. Mother's Name *(First, Middle, Maiden Surname)*: Ethel Kilifer

19a. Informant's Name/Relationship *(Type, Print)*: Dennis Snyder son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O.Box 21, Free Union, Va. 22940

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bayview Crematory | Date: Jan 24, 2001
20c. Location - City or Town, State: Baltimore city

21. Signature of Funeral Service Licensee: Anthony C. Connelly
22. Name and Address of Facility: Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222

Physician /Medical Examiner

23a. Part I: Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Enter only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Tuberculosis — Due to (or as a consequence of): — ± 3 to 6 months or Chronic

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Diabetes mellitus. Chronic — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Malnutrition, Dementia Coronary artery disease CHF, Failure to thrive

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S.S. Jang M.D.
29c. License number: D-17202
29d. Date signed *(Month, Day, Year)*: 1/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S.S. JANG M.D. 101 St Helena Ave Baltimore Md 21222

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001
32. Registrar's Signature: Geneva G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 01625

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month Day Year)	3. Time of Death
William Albert Szamborski	January 22 2001	6:15 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Franklin Square Hospital	Rosedale	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-82-0886	1 [X] M 2 [ ] F	41 Yrs.			Feb 5, 1959	Md.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Baltimore	Edgemere	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3148 Main Ave.	21219	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12 yrs.		Mechanic	Baltimore City

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Albert Szamborski	Josephine Hartman

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Audre Szamborski wife	3148 Main Ave, Edgemere, Md. 21219

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Sacred Heart of Jesus	Jan. 26, 2001	Dundalk, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Anthony C. Connelly	Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardio-Pulmonary Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Morbid Obesity

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown	23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnency 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	23d. Date of delivary Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown		
24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No	24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No	

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No	26. Place of Death (Check only one) Hospital: 1 [ ] Inpatient 2 [✓] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 [ ] Yes 2 [ ] No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [✓] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Charles F. O'Donnell MD	D-09383	January 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles F. O'Donnell MD 111 Hamlet Ct. Baltimore Md 21210

State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signature
	JAN 24 2001	Donna B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01626

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JENNIE F. SCHAFFER
2. Date of Death (Month, Day, Year): JANUARY 8, 2001
3. Time of Death: 7:20PM

4a. Facility Name (If not institution, give street and number): MARINER HEALTH OF BETHESDA
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 012-22-7325
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 19, 1905
9. Birthplace (State or Foreign Country): OHIO

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: POTOMAC
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 11804 HUNTING RIDGE COURT
10f. Zip Code: 20854
10g. Citizen of What Country?: UNITED STATES

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): LOUIS SIMON
18. Mother's Neme (First, Middle, Maiden Surname): REBECCA "UNKNOWN"

19a. Informent's Neme/Reletionship (Type, Print): MARK LOUIS SCHAFFER/ SON
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 11804 HUNTING RIDGE CT., POTOMAC, MD 20854

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): GARDEN OF REMEMBRANCE
Date: 01/10/01
20c. Location - City or Town, State: CLARKSBURG, MD

21. Signeture of Funeral Service Licensee: Donald C. Stottlemyer
22. Name and Address of Facility: DANZANSKY GOLDBERG MEMORIAL CHAPEL, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Final diseese or condition resulting in death)
a. PNEUMONIA — DAYS
Due to (or es e consequenca of):
b. CONGESTIVE HEART FAILURE — YEARS

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) end menner steted.

29b. Signature and title of certifier: Gabriel A Berrebi
29c. License number: D 30692
29d. Date signed (Month, Dey, Year): JANUARY 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GABRIEL A. BERREBI, MD 15225 SHADY GROVE ROAD, #305 ROCKVILLE, MD 20850

State Registrar

31. Dete filed (Month, Day, Year): JAN 24 2001
32. Registrer's Signeture: Frances B. Burke

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01627

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOE STARKS
2. Date of Death: Month JAN. Day 17 Year 2001
3. Time of Death: 2 10 PM
4a. Facility Name (If not institution, give street and number): 3227 SPAULDING AVENUE
4b. City, Town, or Location of Death: BALTIMOR
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 251 54 0099
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APR. 14, 1940
9. Birthplace (State or Foreign Country): S. Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: BALTIMOR
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 3227 Spaulding Ave
10f. Zip Code: 21215
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 4-19-57 6-3-59
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 11th grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Letter Carrier
16b. Kind of Business/Industry: U.S. Postal Service

17. Father's Name (First, Middle, Last): Freddie Starks
18. Mother's Name (First, Middle, Maiden Surname): Alineesse Winemaker

19a. Informant's Name/Relationship (Type, Print): Roslyn Starks /wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3227 Spaulding Ave Baltimor, Md 21215

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Garrison Forest Veterans Cemetery
Date: 1-23-2001
20c. Location - City or Town, State: Owings Mills, Md

21. Signature of Funeral Service Licensee: Gary Harris
22. Name and Address of Facility: CHATHAM-HARRIS Funeral Home 5200 Reisterstown Road Baltimor, Maryland 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. METASTATIC LUNG CA — 10 mos

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Flavio Kruter
29c. License number: D35398
29d. Date signed (Month, Day, Year): 1-22-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FLAVIO KRUTER 555 SOUTH CENTER ST WESTMINSTER MD 21157

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: Barbara B. Sparks

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Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01628

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Cecil Earl Spitzer
2. Date of Death Month: 01 Day: 21 Year: 2001
3. Time of Death: 5:00 PM
4a. Facility Name *(If not institution, give street and number)*: 709 Hampton Lane
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-46-2054
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 93 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 08/22/1907
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 709 Hampton Lane
10f. Zip Code: 21286
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1929-1956
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Commander
16b. Kind of Business/Industry: United States Navy

17. Father's Name *(First, Middle, Last)*: unknown
18. Mother's Name *(First, Middle, Maiden Surname)*: unknown

19a. Informant's Name/Relationship *(Type, Print)*: Barbara Lowenthal / daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 709 Hampton Lane; Towson, MD 21286

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hilltop Service Corp
Date: 1/24/01
20c. Location - City or Town, State: Towson, MD

21. Signature of Funeral Service Licensee: Peter U Clay
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, MD 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Colon Cancer
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: 046197
29d. Date signed *(Month, Day, Year)*: 1/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Saverio Mirarchi MD 3100 Wyman Park Dr., Baltimore, MD 21211

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001
32. Registrar's Signature:

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01629

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: TERRY SAULS BURY

2. Date of Death Month / Day / Year: JANUARY 20 2001

3. Time of Death: 10:57A.M

4a. Facility Name *(If not institution, give street and number)*: THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: NA

Funeral Director

5. Social Security Number: 215-74-8352

8. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 41 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 08-20-59

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2022 E. Jefferson Street

10f. Zip Code: 21205

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12th grade

College (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Telecommunication

16b. Kind of Business/Industry: Company

17. Father's Name *(First, Middle, Last)*: William Pompey

18. Mother's Name *(First, Middle, Maiden Surname)*: Helen Pompey

19a. Informant's Name/Relationship *(Type, Print)*: Bryan M. Saulsbury

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2022 E. Jefferson Street Baltimore, Maryland 21205

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Voshell Mem. Gardens

Date: 01-25-2001

20c. Location - City or Town, State: Dundalk, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: WM.C.March FH 1101 E. North Avenue Baltimore, Maryland 21202

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	SPONTANEOUS BACTERIAL PERITONITIS	5 DAYS
Due to (or as a consequence of): b.	CIRRHOSIS	3 YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: [signature], MD

29c. License number: CES 000

29d. Date signed *(Month, Day, Year)*: JANUARY 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter V. Johnston, MD 600 N. Wolfe St Baltimore, MD 21287

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001

32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01630

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NATHAN SCHWARTZ

2. Date of Death (Month, Day, Year): JANUARY 21, 2001

3. Time of Death: 4:50 AM

4a. Facility Name (If not institution, give street and number): POTOMAC VALLEY NURSING AND WELLNESS CENTER

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 099-01-8731

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JAN 21, 1911

9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: MD

10b. County: MONTGOMERY

10c. City, Town or Location: POTOMAC

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 10020 COLEBROOK AVENUE

10f. Zip Code: 20854

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BUSINESS OWNER

16b. Kind of Business/Industry: ALUMINUM PRODUCTS

17. Father's Name (First, Middle, Last): OSIAH SCHWARTZ

18. Mother's Name (First, Middle, Maiden Surname): MINERVA HERMAN

19a. Informant's Name/Relationship (Type, Print): LOIS BERKMAN/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10020 COLEBROOK AVENUE, POTOMAC, MARYLAND 20854

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): NATIONAL F.H. CREMATORY

Date: JAN 24, 2001

20c. Location - City or Town, State: FALLS CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ALZHEIMERS DISEASE	1 YR
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D01120

29d. Date signed (Month, Day, Year): JANUARY 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 1235 POTOMAC VALLEY ROAD, ROCKVILLE, MARYLAND 20851 DR. WALTER GOOZH

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01631

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LESTER SCHLEPARK
2. Date of Death (Month, Day, Year): JANUARY 20, 2001
3. Time of Death: 12:49 PM
4a. Facility Name (If not institution, give street and number): HOLY CROSS HOSPITAL
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 020-18-5392
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN 10, 1916
9. Birthplace (State or Foreign Country): MASS.

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: TAKOMA PARK
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 7051 CAROL AVENUE #1008
10f. Zip Code: 20912
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): VARIED
16b. Kind of Business/Industry: ARMY

17. Father's Name (First, Middle, Last): WILLIAM SCHLEPARK
18. Mother's Name (First, Middle, Maiden Surname): MILDRED COHEN

19a. Informant's Name/Relationship (Type, Print): HARRIET SCHELPARK/SISTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7217 16TH AVE, TAKOMA PARK, MARYLAND 20912

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARLINGTON NATIONAL CEMTRY | Date: JAN 29, 2001
20c. Location - City or Town, State: ARLINGTON, VIRGINIA

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. SEPSIS
Due to (or as a consequence of):
b. PNEUMONIA
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
c. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D0052927
29d. Date signed (Month, Day, Year): JANUARY 20, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE IGWEBE, MD 1500 FOREST GLEN ROAD, SILVER SPRING, MARYLAND 20910

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: [signature]

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01632

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SARA M. GILLEY SGRO1

2. Date of Death (Month, Day, Year): JAN 18, 2001

3. Time of Death: 10:30 AM

4a. Facility Name *(If not institution, give street and number)*: MANOR CARE - TOWSON

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 577-28-5963

6. Sex: 1☐ M 2☑ F

7. Age *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MARCH 1, 1923

9. Birthplace *(State or Foreign Country)*: TENNESSEE

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: TOWSON

10d. Inside City Limits: 1☐ Yes 2☑ No

10e. Street and Number: 305 E. JOPPA RD. #803

10f. Zip Code: 21286

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☑ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SECRETARY

16b. Kind of Business/Industry: BENDIX CORP.

17. Father's Name *(First, Middle, Last)*: JOSEPH GILLEY

18. Mother's Name *(First, Middle, Maiden Surname)*: CLARA SMITH

19a. Informant's Name/Relationship *(Type, Print)*: BLAINE TAYLOR, SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 203 E. JOPPA RD. #709 TOWSON, MD. 21286

20a. Method of Disposition: 1☐ Burial 2☑ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: EVANS FUNERAL CHAPEL BEL AIR - P.A.

Date: JAN. 19 2001

20c. Location - City or Town, State: FOREST HILL, MD

21. Signature of Funeral Service Licensee: Jason [illegible]

22. Name and Address of Facility: EVANS FUNERAL CHAPEL 3300 HARFORD RD. PARKVILLE, MD. 21234

Physician ~~Medical~~ Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Chronic Obstructive Lung disease — 8 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible]

29c. License number: D20658

29d. Date signed *(Month, Day, Year)*: JAN 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CARL FRIEDMAN, MD. 515 FAIRMOUNT AVE #310 TOWSON, MD. 21286

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001

32. Registrar's Signature: [illegible]

ORIGINAL

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01633

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HENRY STIPEK

2. Date of Death Month / Day / Year: JANUARY 22 2001

3. Time of Death: 4:50 P.M.

4a. Facility Name *(If not institution, give street and number)*: 2918 SUMMIT AVE.

4b. City, Town, or Location of Death: LARNEY

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 213-12-4834

6. Sex: [X] 1 M 2 F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MARCH 27, 1920

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: BALTIMORE

10c. City, Town or Location: LARNEY

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 2918 SUMMIT AVE.

10f. Zip Code: 21234

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: W.W.II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 YRS; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SHIPPING

16b. Kind of Business/Industry: INTERNATIONAL PAPER COMPANY

17. Father's Name *(First, Middle, Last)*: VINCENT STIPEK

18. Mother's Name *(First, Middle, Maiden Surname)*: FRANCES DOBRY

19a. Informant's Name/Relationship *(Type, Print)*: GERALDINE STIPEK

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2918 SUMMIT AVE. LARNEY, MARYLAND 21234

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: EVANS FUNERAL CHAPEL — BEL AIR, P.A.

Date: JAN. 25, 2001

20c. Location - City or Town, State: FOREST HILL, MARYLAND

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD PARKVILLE MARYLAND 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE — 1 HR.

Due to (or as a consequence of):

b. CORONARY ARTERY DIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D083 44

29d. Date signed *(Month, Day, Year)*: JANUARY 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ORLUIS RIVERA, M.D. 5714 HARFORD ROAD BALTIMORE, MARYLAND

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001

32. Registrar's Signature: [signature] G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

AMENDED ITEM #4b & 18 per fh G791 012401 SS

Reg. No 2001 01634

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Betty THAMAN

2. Date of Death: Month JAN Day 21 Year 2001

3. Time of Death: 0305 AM

4a. Facility Name (If not institution, give street and number): Howard County General Hospital

4b. City, Town, or Location of Death: ~~Columbia~~ Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 114-09-1915

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 15 1909

9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6334 Cedar Lane

10f. Zip Code: 21044

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookkeeper

16b. Kind of Business/Industry: Unknown

17. Father's Name (First, Middle, Last): Nathan Wolodarsky

18. Mother's Name (First, Middle, Meiden Surname): Pessa ~~Libi~~ Liba Lubogonsky

19a. Informent's Neme/Relationship (Type, Print): Evelyn F. Lifschitz Niece

19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7070 Cradlerock Way Columbia, MD 21045

20a. Method of Disposition: 1☒ Burial 2☐ Cremelion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Har Jehuda Cemetery

Date: 01/24/01

20c. Location - City or Town, State: Upper Darby, PA

21. Signeture of Funeral Service Licensee

22. Name and Address of Facility: Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Finel disease or condition resulting in death)

a. pNeumonia — Days

Due to (or as s consequence of):

b. Dementia — yrs

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributs to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete end placa, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and menner stated.

29b. Signeture and title of certifier

29c. License number: D-34868

29d. Date signed (Month, Day, Year): JAN 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S Diener 1105 T Little Patuxent Parkway Columbia, MD 21044

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01635

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HELEN TILLERY
2. Data of Death — Month: JAN Day: 23 Year: 2001
3. Time of Death: 9:00 AM
4a. Facility Name (If not institution, give street and number): Howard County Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 224-20-8043
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Sept 29 1908
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2801 Sunset Drive
10f. Zip Code: 21223
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress
16b. Kind of Business/Industry: Pin up Poster Company

17. Father's Name (First, Middle, Last): William G. Morgan
18. Mother's Name (First, Middle, Maiden Surname): Lydia E. Baker

19a. Informant's Name/Relationship (Type, Print): Helen Sutton - granddaughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5771 Augustine Avenue, Elkridge, Maryland 21075

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Baltimore National Cem.
Date: 1/26/01
20c. Location - City or Town, State: Catonsville, Maryland

21. Signature of Funeral Service Licensee: Juanita R Thomas
22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	ASPIRATION PNEUMONIA	24 hrs
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.		
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DIABETES

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D51860
29d. Date signed (Month, Day, Year): JAN 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JONATHAN FISH MD 3460 ELLICOTT CTR DR #103 ELLICOTT CITY MD 21043

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01636

Vonasek Wenceslaus

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WENCESLAUS ALBERT VONASEK
2. Date of Death — Month: JANUARY; Day: 21; Year: 2001
3. Time of Death: 11:29 PM
4a. Facility Name *(If not institution, give street and number)*: GREATER BALTIMORE MEDICAL CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-14-7749
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: OCT. 19, 1918
9. Birthplace *(State or Foreign Country)*: MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: PARKVILLE
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 2606 JERALD DRIVE
10f. Zip Code: 21234
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Yeer or Detes:
13. Wes Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 YRS. — College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MACHINE SETTER
16b. Kind of Business/Industry: WESTERN ELECTRIC

17. Father's Neme *(First, Middle, Last)*: FRANCIS M. VONASEK
18. Mother's Name *(First, Middle, Maidan Surname)*: ANNA KUBA

19a. Informant's Neme/Reletionship *(Type, Print)*: ELIZABETH A. VONASEK
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2606 JERALD DRIVE PARKVILLE, MARYLAND 21234

20a. Method of Disposition: 1 ☒ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, crematory or other piece)*: HOLY ROSARY
Dete: JAN. 25 2001
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee ▶
22. Neme end Address of Facility: EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD PARKVILLE MARYLAND 21234

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heert teilure. List only one cause on aech lina.

Approximate Interval Between Onset and Deeth

Immediete Cause (Final disease or condition resulting in deeth):
e. myocardial infarction — minutes

Due to (or as a consequanca of):
b. coronary artery disease — years

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
c. chronic renal failure — years

Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Wes an eutopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Wes casa referred to medical exeminer? 1 ☐ Yes 2 ☒ No

28. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other *(Specify)*

27. Menner of Deeth: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicida 5 ☐ Pending Investigetion 6 ☐ Could not be determined

28e. Dete of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶
29c. License number: D27310
29d. Date signed *(Month, Day, Year)*: 1/22/01

30. Name and address of person who completed cause of death (item 23e) (Type, Print): Jeffrey N. Posner, MD 1838 Green Tree Rd, Balt, MD 21208

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001
32. Registrar's Signature ▶

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01637

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Irvin S. Williams

2. Date of Death — Month: January Day: 22 Year: 2001

3. Time of Death: 14:30

4a. Facility Name (If not institution, give street and number): 327 Suter Rd., Apt A

4b. City, Town, or Location of Death: CATONSVILLE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 212-12-7918

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPT 1, 1920

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: BALTIMORE

10c. City, Town or Location: CATONSVILLE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 327 SUTER RD., APT A

10f. Zip Code: 21228

10g. Citizen of What Country?: U.S.A.

11. Meritat Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Yeer or Dates: 42/46

13. Was Decedent of Hispenic Origin? (Specify Yes or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): unknown — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LEVATOR OPERATOR

16b. Kind of Business/Industry: FIDELITY & DEPOSIT CO.

17. Father's Neme (First, Middle, Last): GEORGE WILLIAMS

18. Mother's Nama (First, Middle, Maiden Surname): ELLA GARNER

19a. Intormant's Neme/Raletionship (Type, Print): Sheila D. Webb/Niece

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 171 Winters Ln., Catonsville, Md., 21228

20a. Method ot Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Plece of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST — Deta: 1-29-01

20c. Location - City or Town, State: OWINGS MILLS, MD

21. Signature of Funeral Service Licensee: Charles K. Powell

22. Name end Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or raspiretory errast, shock, or heart teilure. List only one cause on each line.

		Approximata Interval Between Onset end Death
Immediate Ceuse (Finel disease or condition resulting in death) a.	Arteriosclerotic Cardiovascular Disease	30yrs
Due to (or as a consequence of): b.	Carcinoma of Prostate	5yrs
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last — Due to (or es a consequence of): c.	Hypertension	15yrs
Due to (or es a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uas contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Was casa raterred to medicat exeminer? 1 [X] Yes 2 [ ] No

26. Plece of Death (Check only one) — Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner ot Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Dascribe how injury occurred

28e. Plece ot Injury - At home, tern, atreet, tectory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best ot my knowledge, daeth occurred at the time, date and place, and dua to tha causa(s) and mannar as statad. 2 [X] **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, daath occurred et tha time, dete end place, and due to the cause(s) end mennar steted.

29b. Signeture and title of certifier: Deputy

29c. License number: D18667

29d. Date signed (Month, Day, Year): January 24, 2001

30. Neme end address of person who completed cause ot deeth (Item 23a) (Type, Print): PHILIP MILITELLO, MD SHOCK TRAUMA 22 S. Greene ST. Baltimore, Md 21201

State Registrar

31. Dete tiled (Month, Day, Year): JAN 24 2001

32. Registrar's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01638

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Billie J Westfall

2. Date of Death: Month January Day 20 Year 2001

3. Time of Death: 6.26PM

4a. Facility Name (If not institution, give street and number): Harbor Hospital Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-80-9232

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 41 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 2, 1959

9. Birthplace (State or Foreign Country): WV

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 1636 South Hanover Street

10f. Zip Code: 21230

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 9

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): Maxwell Buchanan

18. Mother's Neme (First, Middle, Meiden Surneme): Betty Oxley

19a. Informant's Neme/Reletionship (Type, Print): Lynn Bowyer / Sister

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 1470 Stevenson Street, Baltimore Maryland 21230

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, crematory or other piece): Voshell Memorial Gardens

Data: January 23, 2000

20c. Location - City or Town, Stete: Baltimore Maryland

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.

22. Nama and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immedlete Ceuse (Finel disease or condition resulting in death):

a. septic shock — 3 days

Due to (or es a consequenca of):

b. cellulitis — 5 days

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last

Due to (or as e consequenca of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Pert I: Diabetis Mellitus, Hypertension, Obesity

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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Division of Vital Records, P.O. Box 68760,

29e. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) end mennar steted.

29b. Signature and title of certifier: Mohanad Bakleh MD

29c. Licansa number: RES000

29d. Deta signed (Month, Day, Year): 01/20/2001

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Mohanad Bakleh, MD 3001 S. Hanover street, Baltimore, MD 21225

State Registrar

31. Dete filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signeture: [illegible] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01639

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sanford L. White
2. Date of Death: Month 01 Day 21 Year 2001
3. Time of Death: 5:49p.m.
4a. Facility Name (If not institution, give street and number): Joseph Richey Hospice
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 217-34-0233
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02 28 39
9. Birthplace (State or Foreign Country): M.D.

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 7002 Surrey Drive
10f. Zip Code: 21215
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+): na
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Beth Steel Company

17. Father's Name (First, Middle, Last): Elliot White
18. Mother's Name (First, Middle, Maiden Surname): Elsie Dunlap

19a. Informant's Name/Relationship (Type, Print): Patricia White-Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7002 Surrey Drive, Baltimore Md 21215

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Vet.
Date: 1/25/01
20c. Location - City or Town, State: Owigns Mills, Md

21. Signature of Funeral Service Licensee: John B. Johnson
22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Pancreatic adenocarcinoma — 1 Month

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus Type II
Liver Failure
Renal Failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Brent B. Macdonald, MD
29c. License number: D47105
29d. Date signed (Month, Day, Year): 1/22/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Brent Macdonald 2400 Kirk Ave, Balt, MD 21218

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5:49 PM JANUARY 21, 2001 SANFORD WHITE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01640

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FREDA WEINBERG

2. Date of Death (Month, Day, Year): JANUARY 22, 2001

3. Time of Death: 7:50 AM

4a. Facility Name *(If not institution, give street and number)*: Homewood at Crumland Farms

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 577-54-6321

6. Sex: 1☐ M 2☐ F

7. Age *(In yrs. last birthday)*: 94 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: OCT 20, 1906

9. Birthplace *(State or Foreign Country)*: NEW YORK

Usual Residence of Decedent

10a. State: MD

10b. County: FREDERICK

10c. City, Town or Location: FREDERICK

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2213 GARDEN LANE

10f. Zip Code: 21701

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SELF EMPLOYED

16b. Kind of Business/Industry: GROCERY

17. Father's Name *(First, Middle, Last)*: DAVID GERSHONWITZ

18. Mother's Name *(First, Middle, Maiden Surname)*: HANNAH SCHEMSHENOVITZ

19a. Informant's Name/Relationship *(Type, Print)*: STANLEY WEINBERG/SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2213 GARDEN LANE, FREDERICK, MARYLAND 21701

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: KING DAVID MEMORIAL GDNS

Date: JAN 25, 2001

20c. Location - City or Town, State: FALLS CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: DO

29c. License number: DO 7186

29d. Date signed *(Month, Day, Year)*: 01-22-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. PHILIP SHAPIRO, 7407 WILLOW ROAD, FREDERICK, MARYLAND 21702

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001

32. Registrar's Signature

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

known to Physicians as: Freda Weinberg Top: 7:50am DOD 1-22-01

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01641

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rhoda Zurbaskin
2. Date of Death (Month, Day, Year): January 22 2001
3. Time of Death: 1552
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 212-42-5272
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar 22, 1936
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1301 Anglesea Street
10f. Zip Code: 21224
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Julius E. Goldberg
18. Mother's Name (First, Middle, Maiden Surname): Rena Zurbaskin

19a. Informant's Name/Relationship (Type, Print): Leon Goldberg
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6718 Chippewa Drive Baltimore, MD 21209

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Carroll Cremation Serv.
Date: 1/23/01
20c. Location - City or Town, State: Hampstead, Maryland

21. Signature of Funeral Service Licensee: Stephen M Jenkins
22. Name and Address of Facility: Eline Funeral Home 11824 Reisterstown Road Reisterstown, MD 21136

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Acute Renal failure
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Rhabdomyolysis
Due to (or as a consequence of):
c. Cerebrovascular Accident
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: RES. 000
29d. Date signed (Month, Day, Year): January 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Anna Hemmes 4940 Eastern Avenue Baltimore Maryland 21224

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: Geneva B. Sparks

ORIGINAL

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01642

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SADIE FORSYTHE ASPINALL
2. Date of Death (Month, Day, Year): JANUARY 5, 2001
3. Time of Death: 3:12 P.M.
4a. Facility Name (If not institution, give street and number): GARRETT COUNTY MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: OAKLAND
4c. County of Death: GARRETT

Funeral Director

5. Social Security Number: 125-32-5046
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN 23, 1909
9. Birthplace (State or Foreign Country): NEW YORK

Usuet Residenca of Decedent

10a. Stete: MD
10b. County: GARRETT
10c. City, Town or Location: OAKLAND
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 22 N. SECOND STREET
10f. Zip Code: 21550
10g. Citizen of What Country?: USA
11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 5+ | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHER
16b. Kind of Business/Industry: EDUCATION
17. Father's Neme (First, Middle, Last): WILLIAM L. GERARD
18. Mother's Name (First, Middle, Maiden Surname): SADIE RITTER
19a. Informent's Neme/Relationship (Type, Print): WILLIAM ASPINALL - SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 22 N. SECOND ST. OAKLAND, MARYLAND 21550
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HUNTINGTON RURAL CEM.
Date: 1/11/01
20c. Location - City or Town, State: HUNTINGTON, NY
21. Signeture of Funeral Service Licensee: Robert H. Durst M00167
22. Name and Address of Facility: P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death): e. Acute Cerebral Vascular — 2 days

Due to (or as a consequence of):

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest:

b. Hypertension — Many Years

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Coronary Artery Disease with angina & heart failure

Fractured pelvis, left, Osteoporosis, Dementia

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturet 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture and title of certifier: Margaret A. Kaiser M.D.
29c. License number: D26650
29d. Date signed (Month, Day, Year): 1/5/01

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print): Margaret A. Kaiser, M.D. 13079 Garrett Highway Oakland, MD 21550

12

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN - 8 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 01643

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ann M. Alster

2. Date of Death Month Day Year: January 9, 2001

3. Time of Death: 6:45 AM

4a. Facility Name *(If not institution, give street and number)*: Shady Grove Nursing Home

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 136-05-1127

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 6, 1915

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: FL

10b. County: Palm Beach

10c. City, Town or Location: Boca Raton

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3021 Lincoln B

10f. Zip Code: 33434

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Banker

16b. Kind of Business/Industry: Finance

17. Father's Name *(First, Middle, Last)*: Isadore Meit

18. Mother's Name *(First, Middle, Maiden Surname)*: Bertha Roth

19a. Informant's Name/Relationship *(Type, Print)*: Phyliss Alster Fogelson (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 69 Taylortown Road Montville, NJ 07045

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: New Mt. Lebanon Cemetery

Date: 1/11/01

20c. Location - City or Town, State: Iselin, NJ

21. Signature of Funeral Service Licensee: Dennis G. Cottone

22. Name and Address of Facility: Metropolitan Funeral Service 5517 Vine Street Alexandria, VA 22310

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Severe Anorexia with Inanition	2 Months
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Non Hodgkins Lymphoma	8 Months
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Carcinoma of the Sigmoid Colon

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James G. Brown, MD

29c. License number: D07285

29d. Date signed *(Month, Day, Year)*: January 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James D. Brown M.D. 9708 Medical Center Dr. Rockville, MD 20850

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend#23a & 26
Amend Item#17 HCHD 1-09-01 BRH

Certificate of Death

Reg. No. 2001 01644

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Elizabeth Ann Bochniak	January 6, 2001	12:40 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
502 Copeland Road	Fallston	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-36-8325	1☐ M 2☒ F	60 Yrs.			Feb. 14, 1940	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Baltimore	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9515 Perry Hall Blvd.	21236	U.S.A.

11. Meritel Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specity Cuban, Mexicen, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Detes:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Eduction (Specify only highest grade completed)		16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
12th Grade		Bookkeeper	Gasoline Company

17. Father's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
~~William~~ Leo Lanahan, Sr. ~~Lanahan~~	Regina Potter

19e. Informent's Neme/Reletionship (Type, Print)	19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Mr. Eugene J. Bochniak (husband)	9515 Perry Hall Blvd., Baltimore, MD 21236

20e. Method of Disposition	20b. Piece of Disposition (Name of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1☐ Buriel 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)	Green Mount Crematory	1/10/01	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name end Address of Facility
Christina L. David	Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cerdiec or respiratory errest, shock, or heert feilure. List only one ceuse on eech line.

		Approximete Intervel Between Onset and Deeth
Immediete Cause (Finel diseese or condition resulting in deeth)	a. ~~Coneulung~~ CARCINOMA OF THE LUNG	1 month
	Due to (or as e consequence of):	
Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	b.	
	Due to (or es e consequence of):	
	c.	
	Due to (or es a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Wes case referred to medicet exeminer?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☒ Other (Specify) Daughter's Residence

27. Manner of Death	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner es stated.
2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the ceuse(s) and menner steted.

29b. Signeture end title of certifier	29c. License number	29d. Dete signed (Month, Dey, Year)
MD	D18487	1/8/01

30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print)
MYO THANT 6830 HOSPITAL DRIVE, BALTO, MD 21237

State Registrar

31. Date filed (Month, Day, Year)	32. Registrer's Signature
JAN 10 2001	B. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

BH

12

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01645

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CLINE ELMO BRENDLE

2. Date of Death (Month, Day, Year): January 4, 2001

3. Time of Death: 2320

4a. Facility Name *(If not institution, give street and number)*: Upper Chesapeake Medical Center

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 240-16-6549

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Mar. 1, 1923

9. Birthplace *(State or Foreign Country)*: N. Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: ☒ 1 Yes 2 ☐ No

10e. Street and Number: 1 North Atwood Road

10f. Zip Code: 21014

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? ☒ 1 Yes 2 ☐ No If Yes, Give Year or Dates: 1941-76

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes ☒ 2 No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: U.S. Military

16b. Kind of Business/Industry: U.S. Government

17. Father's Name *(First, Middle, Last)*: Marle Berlin Brendle

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Ellen McClure

19a. Informant's Name/Retelionship *(Type, Print)*: James E. Massey, Jr. - Nephew

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1 North Atwood Road, Bel Air, Maryland 21014

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bel Air Memorial Grdns.

Date: 1/8/01

20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: ▶ Kelly McComas Pennington

22. Name and Address of Facility: McComas Funeral Home, P.A. 50 West Broadway, Bel Air, Maryland 21014

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or raspiretory arrest, shock, or heart feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. End-Stage Respiratory Failure — days.

Due to (or as a consequenca of):

b. Chronic and Acute Aspiration pneumonia — Months

Due to (or es a consequence of):

c. Severe Esophageal motility disorder. — Months

Due to (or as a consequence of):

d. Insulin dependent diabetes mellitus — years.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated evants resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part t.

23b. Did tobacco use contributa to the causa of death? 1 ☐ Yaa 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospitel: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other *(Specify)*

27. Menner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of tnjury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and piece, end due to the ceuse(s) and menner as stated. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Albert S.C. Sun, M.D.

29c. License number: D 18779

29d. Date signed *(Month, Day, Year)*: January 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Albert S.C. SUN, M.D. 1716 Harford Road Ste. 105 Fallston MD 21047

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 08 2001

32. Registrer's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Brendle, Cline Elmo ZM

15+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01646

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Leora Mae Butler

2. Data of Death — Month: Jan Day: 04 Year: 2001

3. Time of Death: 3 Am

4a. Facility Name (If not institution, give street and number): Goodwill Mennonite Home

4b. City, Town, or Location of Death: Grantsville

4c. County of Death: Garrett

Funeral Director

5. Social Security Number: 175-20-2208

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 96 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Data of Birth (Month, Day, Year): Apr. 4, 1904

9. Birthplace (State or Foreign Country): Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: PA

10b. County: Somerset

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 156 Park Avenue

10f. Zip Code: 15558

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 8 th — College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): George McKenzie

18. Mother's Name (First, Middle, Maiden Surname): Ellen Lowry

19a. Informant's Name/Relationship (Type, Print): Doyle E. Paul/Great Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 193 Broadway, Berlin, PA 15530

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Salisbury Cemetery, Jan. 7, 2001

20c. Location - City or Town, State: Salisbury, PA

21. Signature of Funeral Service Licensee: ▶ Doyle Newman

22. Name and Address of Facility: Newman Funeral Homes, P.A., PO Box 275 179 Miller St., Grantsville, MD 21536

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. FATAL Ventricular Arrhythmia — mins

Due to (or as a consequence of):
b. Congestive heart Failure — 5 years.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Coronary Artery disease — 5 Years

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular disease.
Infected by ulcers

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ J E Bell MD

29c. License number: D 34079

29d. Date signed (Month, Day, Year): Jan 04 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James E Bell MD Myersdale PA 15552.

State Registrar

31. Date filed (Month, Day, Year): JAN - 5 2001

32. Registrar's Signature: ▶ Donna D. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01647

AMENDED ITEM #7 per fh G791 012401 SS

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY J. BROCKLEY

2. Date of Death (Month, Day, Year): January 1 2001

3. Time of Death: 9:05pm

4a. Facility Name (If not institution, give street and number): Union Hospital

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 176-26-8731

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 94 ~~95~~ Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec 15 1906

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD

10b. County: Cecil

10c. City, Town or Location: Earleville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 821 Pond Neck Rd.

10f. Zip Code: 21919

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner Operator

16b. Kind of Business/Industry: Wholesale Nursery

17. Father's Name (First, Middle, Last): Oliver Mullan

18. Mother's Name (First, Middle, Maiden Surname): Mary Williams

19a. Informant's Name/Relationship (Type, Print): Grace Farrow (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 1 Earleville, MD. 21919

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): St. Stephen's Cem. Date: 1/5/01

20c. Location - City or Town, State: Earleville, MD.

21. Signature of Funeral Service Licensee: M00510

22. Name and Address of Facility: Galena Funeral Home of Stephen Schaech 118 West Cross St. Galena, MD. 21635

Physician /Medical Examiner

Cecil Plan

28a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Pneumonia	<1 week
Due to (or as a consequence of): b.	Urinary Tract Infection	<1 week
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	Pulmonary Fibrosis	@ 5 years
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph K. Weidner Jr MD

29c. License number: D44373

29d. Date signed (Month, Day, Year): 1/3/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOSEPH K. WEIDNER JR. MD. 101 COLONIAL WAY RISING SUN MD 21911

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State Registrar

31. Date filed (Month, Day, Year): JAN 03 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01648

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Milton Francis Ceccio

2. Date of Death: Month January Day 5 Year 2001

3. Time of Death: 930pm

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-01-3068

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 15, 1916

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 4610 Mannasota Avenue

10f. Zip Code: 21206

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 6th Grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinist

16b. Kind of Business/Industry: Box Factory

17. Father's Name (First, Middle, Last): Phillip Ceccio

18. Mother's Name (First, Middle, Meiden Surname): Concettina Scarlotta

19a. Informent's Name/Relationship (Type, Print): Regina E. Domanski (Dghtr)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4610 Mannasota Avenue, Baltimore, Maryland 21206

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Sacred Heart of Jesus

Date: 1/9/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis with Cardiogenic shock	1 Day
Due to (or as a consequence of):	b. Pneumonia	3 Day
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: L. Summers MD

29c. License number: RD 196683

29d. Date signed (Month, Day, Year): January 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR LaWanDa Summers 9000 Franklin Square Drive Baltimore Maryland 21237

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Ceccio, Milton

BH

3

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01649

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rosemary Helena Evans
2. Date of Death: Month JANUARY Day 8 Year 2001
3. Time of Death: 2:35 A.M.
4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL CENTER
4b. City, Town, or Location of Death: ROSEDALE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 214-26-0686
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 9, 1930
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4012 Kahlston Road
10f. Zip Code: 21236
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Efford E. Anderson
18. Mother's Name (First, Middle, Maiden Surname): Mary Catherine Thuman

19a. Informant's Name/Relationship (Type, Print): Dr. Theodore E. Evans (husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4012 Kahlston Road, Baltimore, MD 21236

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) Entombment
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Mausoleum
Date: 1/10/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

EVANS, ROSEMARY
Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PULMONARY FIBROSIS
Due to (or as a consequence of):
b. STATUS POST CARDIAC ARREST

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Joel Braunstein MD
29c. License number: D206086
29d. Date signed (Month, Day, Year): 01/08/01
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): JOEL BRAUNSTEIN, MD; 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

Division of Vital Records, P.O. Box 68760, Baltimore, MD 21215-0760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

B.N.

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State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01650

Pt. known as Jne Barber Hunter

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Jane B. Hunter	January	7	2001	5:25p

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SINAI HOSPITAL OF BALTIMORE	BALTIMORE CITY	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-28-4888	1☐ M 2☒ F	72 Yrs.			Oct. 16, 1928	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Baltimore	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
28 W. Orange Ct.	21234	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.)	14. Race - American Indian, Black, Whita, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yas 2☒ No If Yes, Give Year or Datas:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Teacher	Baltimore County Public Schools

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles Baber	Garnet Frasier

19a. Informent's Neme/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Jennean C. Davis (dghtr)	28 W. Orange Ct., Baltimore, MD 21234

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Othar (Specify)	Camp Chapel UMC Cemetery	1/11/01	Perry Hall, Maryland

21. Signeture of Funaral Service Licensee	22. Name and Address of Facility
▶ [signature]	Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Physician /Medical Examiner

BJ.

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onsaf and Death
Immediate Causa (Finel disease or condition resulting in death)	a. Septic Shock	1 day
Due to (or as a consequence of):	b. Pneumonia	8 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest	c. Chronic Obstructive Pulmonary Disease	
Due to (or as e consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did **tobacco use contribute to the causa of death?** 1☒ Yas 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an eutopsy performed?	24b. Were autopsy findings available prior to complation of cause of death?
1☐ Yes 2☒ No	1☐ Yas 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yas 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, death occurred at the fime, dete and place, and due to the ceuse(s) end manner stated.

29b. Signature and title of certifier	29c. Licansa number	29d. Data signed (Month, Day, Year)
▶ [signature] MD	RES 000	January 7, 2001

30. Name end address of person who completed causa of death (Item 23a) (Type, Print)

BRIAN H. GALBUT MD SINAI HOSPITAL 2401 W. BELVEDERE AVE. BALTIMORE, MD 21215

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 09 2001	[signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01651

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SIDNEY HERSH
2. Date of Death (Month, Day, Year): January 17, 2001
3. Time of Death: 2:35A.
4a. Facility Name (If not institution, give street and number): Arden Courts Potomac
4b. City, Town, or Location of Death: Potomac
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 108-12-6114
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug.6,1917
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 4701 Willard Avenue, #1614
10f. Zip Code: 20815
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+): 4
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer
16b. Kind of Business/Industry: Navy Department

17. Father's Neme (First, Middle, Last): Sam Hershkowitz
18. Mother's Name (First, Middle, Meiden Surneme): Hannah Klein

19a. Informant's Name/Relationship (Type, Print): Esther R. Hersh - wife
19b. Melting Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): same as #10a - 10g

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 1/18/2001
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Donald W. Borgwardt
22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Dementia

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Dehydration

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part t.

23b. Did tobacco use contributa to the causa of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy tindings available prior to completion of cause ot death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner:** On the basis of examtnation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sharon A. Scanlon M.D.
29c. License number: D48043
29d. Date signed (Month, Day, Year): January 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sharon A. Scanlon, M.D. 5530 Wisconsin Avenue, #930 Chevy Chase, Maryland 20815

State Registrar

31. Dete filed (Month, Dey, Year): JAN 24 2001
32. Registrer's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0275-001

JAMES B. HALL

ASP amend item 23a,27,28a,b,c,d,e,f per me G791 1/31/01

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01652

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES BRIAN HALL

2. Date of Death: Month JANUARY Day 16 Year 2001

3. Time of Death: 0925

4a. Facility Name (If not institution, give street and number): 205 BALTIMORE ST. APT# 10

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 213-58-8861

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 49 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 16,1952

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: WV

10b. County: Mineral

10c. City, Town or Location: Burlington

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: Rt. 1, Box 214-A

10f. Zip Code: 26710

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self Employed Carpenter

16b. Kind of Business/Industry: Carpentry

17. Father's Name (First, Middle, Last): Walter Scott Hall

18. Mother's Name (First, Middle, Maiden Surname): Mary Jane Norberry

19a. Informant's Name/Relationship (Type, Print): Julie R. Hall/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 1, Box 214-A Burlington, WV 26710

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cabin Run Cemetery

Date: Jan. 21 2001

20c. Location - City or Town, State: Keyser, WV

21. Signature of Funeral Service Licensee: ▶ Brian L. Smith

22. Name and Address of Facility: Smith Funeral Home Rt. 2, Box 1-A Burlington, WV 26710

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory erfest, shock, or heert failure. List only ona ceuse on aech lina.

Approximate Interval Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in death)

a. ALCOHOL AND DRUG INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☑ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) SCENE

27. Manner of Death: 1 ☐ Neturaf 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Dey Year): found: 1/16/01

28b. Time of Injury: found: 9:15 A M

28c. Injury at Work? 1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred: subject ingested drugs and alcohol

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify): found in room

28f. Location (Street and Number or Rural Route Number, City or Town, State) YMCA Cumberland, Md

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: ▶ J Pestaner M.D

29c. License number: O.C.M.E

29d. Date signed (Month, Day, Year): JANUARY 17,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year): JAN 24 2001

32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01653

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Walter Haven
2. Date of Death (Month, Day, Year): January 10, 2001
3. Time of Death: 7:35 AM
4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Hospital
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 035-09-2059
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 01, 1910
9. Birthplace (State or Foreign Country): Rhode Island

Usual Residence of Decedent

10a. State: FL
10b. County: Lake
10c. City, Town or Location: Clermont
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2107 Braxton Street
10f. Zip Code: 34711
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Vice President
16b. Kind of Business/Industry: Citizens Bank

17. Father's Name (First, Middle, Last): Walter Beatty Haven
18. Mother's Name (First, Middle, Maiden Surname): Kate Simmons Thurber

19a. Informant's Name/Relationship (Type, Print): Gilda Haven-Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18204 Hollingsworth Drive Rockville, MD 20855

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 1/11/01
20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: Ellen J. Woodall
22. Name and Address of Facility: Metropolitan Funeral Service, Inc. 5517 Vine St. Alexandria, VA 22310

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute CVA — Minutes
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Atherosclerosis — Years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D
29c. License number: 54135
29d. Date signed (Month, Day, Year): JANUARY 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Duc Tuan Le Shady Grove Adventist Hospital Rockville,Md

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01654

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret Alma Jordan
2. Date of Death (Month, Day, Year): January 8, 2001
3. Time of Death: 3:55 AM
4a. Facility Name (If not institution, give street and number): Genesis Elder Care-Perring Parkway
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-03-9608
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 30, 1919
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9916 Finney Drive
10f. Zip Code: 21234
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th Grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): James Streb
18. Mother's Name (First, Middle, Maiden Surname): Katherine Kunkel

19a. Informant's Name/Relationship (Type, Print): Mrs. Eileen Dentry (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9916 Finney Drive, Baltimore, MD 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, cramatory or other place): Most Holy Redeemer Cem.
Data: 1/11/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Christina L. David
22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cancer of the Lung — 1 year.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

BH

6

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D-17041
29d. Date signed (Month, Day, Year): 8 January 2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Marc I. Leavey MD 1205 York Road Ste 38 Lutherville MD 21093

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

JUN 08 2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01655

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BARBARA ANN KENDALL
2. Date of Death Month / Day / Year: JAN 8 2001
3. Time of Death: 13:54
4a. Facility Name *(If not institution, give street and number)*: SR HARFORD MEMORIAL HOSP.
4b. City, Town, or Location of Death: HDEG
4c. County of Death: HARFORD.

Funeral Director

5. Social Security Number: 217-62-7015
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 46 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 17, 1954
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Aberdeen
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 14 Church Green
10f. Zip Code: 21001
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No — Specify:
14. Race - American Indian, Black, White, etc. — Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: William (nmn) Smith, Jr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Bertha Lillian Klingel

19a. Informant's Name/Relationship *(Type, Print)*: George Monroe Kendall / Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14 Church Green, Aberdeen, Maryland 21001

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Bel Air Memorial Gardens
Date: 1-12-01
20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: McComas Funeral Home, P.A. 50 W. Broadway Street, Bel Air, MD 21014

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. A SCVD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DIABETES Mellitus Type I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] DME
29c. License number: OCME
29d. Date signed *(Month, Day, Year)*: JAN 8 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): G PRABHU MD 728 BELAIR RD BELAIR MD 21014

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001
32. Registrar's Signature: [signature] D. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Dr. Prabhu 1354 1-8-01 BH. Kendall, Barbara 5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01656

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Julianna Lynn
2. Date of Death (Month, Day, Year): January 6, 2001
3. Time of Death: 1:35 PM
4a. Facility Name *(If not institution, give street and number)*: 318 E. Belcrest Road
4b. City, Town, or Location of Death: Bel Air
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 218-09-2295
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 1, 1919
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Bel Air
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 318 E. Belcrest Road
10f. Zip Code: 21014
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 10th Grade | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life, DO NOT use retired)*: Printing Inspector/ Color Coordinator
16b. Kind of Business/Industry: Paper

17. Father's Name *(First, Middle, Last)*: Michael Blama
18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Koval

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Tammy Stark (Friend)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1941 Mark Drive, Edgewood, Maryland 21040

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Bel Air Memorial Gardens
Date: 1/9/01
20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Schimunek Funeral Home of Bel Air Inc. 610 W. Macphail Road, Bel Air, Maryland 21014

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Chronic Respiratory Failure — years

Due to (or as a consequence of):
b. Sleep Apnea Syndrome — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Morbid Obesity — years

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypothyroidism
History of Breast cancer, Right

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] P. Valarao M.D.
29c. License number: D0016389
29d. Date signed *(Month, Day, Year)*: January 8, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Perfecto Valarao, 1716 Harford Road, Fallston, Md.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01657

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROXANNE SWAYNEY LAMBERT
2. Date of Death: Month JANUARY Day 08 Year 2001
3. Time of Death: 0320
4a. Facility Name (If not institution, give street and number): Upper Chesapeake Medical Center
4b. City, Town, or Location of Death: Bel Air
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 216-24-6489
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar. 17, 1921
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Hydes
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3003 Harford Road
10f. Zip Code: 21082
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elamantary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assembly Line Worker
16b. Kind of Business/Industry: Electronics Manufacturer

17. Father's Name (First, Middle, Last): John Wesley Swayney
18. Mother's Name (First, Middle, Maiden Surname): Nettie Emily Williamson

19a. Informant's Name/Relationship (Type, Print): Jerry Lambert / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 638 Burlington Ct., Edgewood, MD 21040

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Swayney Farm Cemetery
Date: 1-11-01
20c. Location - City or Town, State: Cherokee, N. Carolina

21. Signature of Funeral Service Licensee: Charles A. Emge
22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or compliations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	RESPIRATORY INSUFFICIENCY	1-2 Days
Due to (or as a consequence of): b.	FLUID OVERLOAD	1-2 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	END STAGE RENAL DISEASE	MONTHS
Due to (or as a consequence of): d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: MALNUTRITION, END STAGE RENAL DISEASE, MULTIPLE MYELOMA, DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Luis F. Gimenez MD
29c. License number: D31960
29d. Date signed (Month, Day, Year): 01/08/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LUIS F. GIMENEZ, M.D. 615 W McPhail Rd Bel Air MD 21014

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01658

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Catherine Elizabeth Murphy
2. Date of Death: Month: January Day: 7 Year: 2001
3. Time of Death: 0628
4a. Facility Name (If not institution, give street and number): 21 N. Paradise Road
4b. City, Town, or Location of Death: Havre de Grace
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 219-10-2435
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 19, 1925
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Havre de Grace
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 21 N. Paradise Road
10f. Zip Code: 21078
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: In home

17. Father's Name (First, Middle, Last): Edgar Buell
18. Mother's Name (First, Middle, Maiden Surname): Ruth E. France

19a. Informant's Name/Relationship (Type, Print): David P. Murphy (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 21 N. Paradise Rd. Havre de Grace, MD 21078

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cemetery
Date: 1/10/01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ Kenneth B. Cargo
22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC lung cancer — <1 YR.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Hi Sup Sim
29c. License number: D4624
29d. Date signed (Month, Day, Year): 1/08/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Hi Sup Sim 319 S. Union Aberdeen MD 21001

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01659

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charles Henry McDaniel
2. Date of Death Month: 1 Day: 6 Year: 2001
3. Time of Death: 4:00 PM
4e. Facility Name *(If not institution, give street and number)*: 700 East Road
4b. City, Town, or Location of Death: Salisbury
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 217-52-1197
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 51 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 27 1949
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 700 East Road
10f. Zip Code: 21801
10g. Citizen of What Country?: U.S.A

11. Maritel Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Giva Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - Americen Indien, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grede completed)*: Elamantary/Secondary (0-12): 9 — College (1-4or 5+):
16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer
16b. Kind of Businass/Industry: None

17. Father's Name *(First, Middle, Last)*: Willie McDaniel
18. Mother's Name *(First, Middle, Meiden Surneme)*: Mollie Wilson

19a. Informant's Name/Relationship *(Type, Print)*: Mary Watkins (Sister)
19b. Mailing Address *(Streat end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 718 Olivia St.Salisbury,Md.21801

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Christ AME Cemetery — Date: 1/13/01
20c. Location - City or Town, State: Pocomoke,Md.

21. Signature of Funeral Service Licensee: Earl Stewart Jr.
22. Name and Address of Facility: Stewart Funeral Home 821 West Rd.Salisbury,Md.21801

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only ona cause on each line.

		Approximate Interval Betwaan Onset end Death
Immediata Causa (Final disease or condition resulting in death) a.	DIABETES	10 YRS.
Due to (or as a consequence of): b.	SEIZURES.	10YRS.
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Disease or Injury that initiated evants resulting in death) Last — Due to (or as e consequence of): c.	ALCOHOLISM -	15 YRS.
Due to (or as a consequence of): d.	COPD.	

Part II. **Other aignificant conditions** contributing to death but not resulting in the underlying causa givan in Part I.

— CVA.

— Hypertension.

COPD.

23b. Did tobacco use contribute to the causa of death? 1 [ ] Yes 2 [X] No 3 [ ] Probabty 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Wara autopsy findings avellable prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Daath: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Spacify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To tha best of my knowledge, death occurred at the time, data and place, and dua to the causa(s) and mannar as statad. 2 [ ] **Medical Examiner:** On the basis of examination and/or Investigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar statad.

29b. Signature and title of certifier: James W. Isaacs
29c. License number: D14256
29d. Date signed *(Month, Day, Year)*: 1/9/2001

30. Name and address of parson who complated causa of daath (Item 23a) (Type, Print): JAMES W. ISAACS 1001 LAKE ST. SALISBURY MD 21801.

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 0 9 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(5 Ltr)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01660

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Isaak Naygauz
2. Date of Death (Month, Day, Year): January 16, 2001
3. Time of Death: 1:48A.

4a. Facility Name (If not institution, give street and number): Prince George's Hospital
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 220-02-6940
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 61 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb.8,1939
9. Birthplace (State or Foreign Country): Ukrane

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Potomac
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 13 Colebrook Court
10f. Zip Code: 20854
10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): none
16b. Kind of Business/Industry: none

17. Father's Name (First, Middle, Last): Aaron Naygauz
18. Mother's Name (First, Middle, Meiden Sumeme): Rakhil Mandelgeym

19a. Informent's Name/Relationship (Type, Print): Alex Naygauz - brother
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): same as #10a - 10g

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Judean Memorial Gardens
Date: 1/17/01
20c. Location - City or Town, State: Olney, Maryland

21. Signeture of Funerel Service Licensee: ▶ Donald V Borgwardt
22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, PA. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximete Interval Between Onset and Deeth

Immediate Cause (Finel disease or condition resulting in deeth)
a. Pneumonia — 1 day

Due to (or es a consequence of):
b.

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or es a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Multiple Sclerosis
Respiratory failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Deeth (Check only one) Hospitel: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end place, and due to the ceuse(s) end manner as steted. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul A DeVore MD
29c. License number: D01852
29d. Date signed (Month, Day, Year): JANUARY 16, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): PAUL A. DEVORE MD 4203 Queensway Rd Mygttsville MD 20781

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: ▶ Geneva D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01661

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: VIRGIE MARGARET OWEN

2. Date of Death Month: January Day: 8 Year: 2001

3. Time of Death: 1700

4a. Facility Name *(If not institution, give street and number)*: Upper Chesapeake Medical Center

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 223-10-6365

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Mar. 10, 1913

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Fallston

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2838 Harford Road

10f. Zip Code: 21047

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 3 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Assembly Line Worker

16b. Kind of Business/Industry: Shoe Manufacturing

17. Father's Name *(First, Middle, Last)*: George LaFayette King

18. Mother's Name *(First, Middle, Maiden Surname)*: Roxie Mae Waddell

19a. Informant's Name/Relationship *(Type, Print)*: Minnie Foglesong - Niece

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 609 Gap of Ridge Rd., Rural Retreat, VA 24368

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Mitchell Cemetery

Date: 1-12-01

20c. Location - City or Town, State: Wytheville, VA

21. Signature of Funeral Service Licensee: Kelly McComas Pennington

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pancreatic cancer — < 1 week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David S. Dunn

29c. License number: D32279

29d. Date signed *(Month, Day, Year)*: January 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David S. Dunn 615 W. MacPhail

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Owen, Virgie

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01662

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jean Lentz Pumphrey

2. Date of Death (Month, Day, Year): JANUARY 7 2001

3. Time of Death: 4:08 P.M.

4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL of MD, INC

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: —

Funeral Director

5. Social Security Number: 212-28-9919

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 13, 1919

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Glen Arm

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11630 Glen Arm Road, Apt. L36

10f. Zip Code: 21057

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Earl Henry Lentz

18. Mother's Name (First, Middle, Maiden Surname): Phoebe (nmn) Kimble

19a. Informant's Name/Relationship (Type, Print): Earl G. Pumphrey - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2805 Harford Road, Fallston, Maryland 21047

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery

Date: 1/11/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Charles A. Emery

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. acute myocardial infarction minutes

Due to (or as a consequence of):

b. hyperlipidemia years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. hypertension years

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Andrew Sumner MD

29c. License number: D25753

29d. Date signed (Month, Day, Year): January 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Andrew Sumner, MD GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD. BALTO. MD 21239

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

JEAN L. PUMPHREY

BV

20

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01663

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LILLIAN ANNA PETROVIC
2. Date of Death (Month, Day, Year): JAN 04 2001
3. Time of Death: 09-30 HRS
4a. Facility Name (If not institution, give street and number): 20 (SOUTH) BOX HILL PKWY
4b. City, Town, or Location of Death: ABINGDON
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 213-20-6422
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 21, 1924
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Abingdon
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 20 Box Hill South Parkway Apt. 423
10f. Zip Code: 21009
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor
16b. Kind of Business/Industry: Shoe Manufacturer

17. Father's Name (First, Middle, Last): Joseph (nmn) Pokorny
18. Mother's Name (First, Middle, Maiden Surname): Antionette (nmn) Bartinek

19a. Informant's Name/Relationship (Type, Print): David M. Petrovic / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1323 Little Field Place, Bel Air, MD 21015

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp. | Date: 1-8-01
20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Charles A. Emge Jr.
22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ASCVD.
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: OME
29c. License number: OCME
29d. Date signed (Month, Day, Year): JAN 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GS PRABHU MD 728 BELAIR RD BELAIR MD 21014 410-879-6584

State Registrar

31. Date filed (Month, Day, Year): JAN 08 2001
32. Registrar's Signature: S. Hanks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01664

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Hilda Y. Reisman
2. Date of Death (Month, Day, Year): January 18, 2001
3. Time of Death: 3:00A.

4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 215-09-2477
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July30,1919
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9309 Harvey Road
10f. Zip Code: 20910
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: own home

17. Father's Name *(First, Middle, Last)*: Samuel Yerman
18. Mother's Name *(First, Middle, Maiden Surname)*: Shula Miriam Shaivitz

19a. Informant's Name/Relationship *(Type, Print)*: Edwyn Reisman - husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: same as #10a - 10g

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Judean Memorial Gardens
Date: 1/19/2001
20c. Location - City or Town, State: Olney, Maryland

21. Signature of Funeral Service Licensee: By Donald V. Borgwardt
22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):
b. Cerebrovascular Accident - Hemorrhagic
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Cerebrovascular Disease
Due to (or as a consequence of):
d. Hypertension

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gail J. Povar MD
29c. License number: D46101
29d. Date signed *(Month, Day, Year)*: 1/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GAIL J. POVAR MD, 8700 Georgia Ave, Silver Spring, MD 20910

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001
32. Registrar's Signature: Joanne D. Sparks

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01665

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John Joseph Smith
2. Date of Death (Month, Day, Year): January 5, 2001
3. Time of Death: 1308
4a. Facility Name *(If not institution, give street and number)*: Prince George General Hospital
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 218-10-9502
8. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 90 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 15, 1910
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3417 Mayfield Avenue
10f. Zip Code: 21213
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Asst. Building Superintendent
16b. Kind of Business/Industry: Post Office

17. Father's Name *(First, Middle, Last)*: John L. Smith
18. Mother's Name *(First, Middle, Maiden Surname)*: Unknown

19a. Informant's Name/Relationship *(Type, Print)*: Michael J. Boone (Nephew)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2210 Old Largo Road, Upper Marlboro, Md. 20772

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Most Holy Redeemer
Date: 1/9/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Brian D. Fair
22. Name and Address of Facility: Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Md. 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Sepsis — Days – Wks

Due to (or as a consequence of):
b. Dehydration — Days – Wks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Renal Failure — Wks – Month

Due to (or as a consequence of):
d. Alzyhmer disease — Month-Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Decubitus ulcer

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.
29c. License number: D0056184
29d. Date signed *(Month, Day, Year)*: 01/06/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jalal Saied, M.D. 3001 Hospital Dr., Cheverly, MD 20785

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001
32. Registrar's Signature: P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01666

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Janet Louise Schultz
2. Date of Death Month / Day / Year: January 6 2001
3. Time of Death: 9:40 pm
4a. Facility Name *(If not institution, give street and number)*: Stella Maris Nursing Ctr.
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 210-12-3342
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 9, 1923
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10a. Street and Number: 3111 Brendan Avenue
10f. Zip Code: 21213
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales Clerk
16b. Kind of Business/Industry: Retail

17. Father's Name *(First, Middle, Last)*: Edgar J. Harshberger
18. Mother's Name *(First, Middle, Maiden Surname)*: Irene Bell

19a. Informant's Name/Relationship *(Type, Print)*: Mr. Louis Schultz (son)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5927 Greenhill Avenue, Baltimore, MD 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Most Holy Redeemer Cem.
Date: 1/10/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Brian A. Willen
22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D43725
29d. Date signed *(Month, Day, Year)*: 1/9/1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TARIQ MAHMOOD, MD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001
32. Registrar's Signature: [signature] D. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME: SCHULTZ, JANET

BH.

12+1

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01667

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JUANITA L. DAVIS SAVAGE
2. Date of Death (Month, Day, Year): January 5 2001
3. Time of Death: 0730
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 222-30-2925
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 53 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 9, 1947
9. Birthplace (State or Foreign Country): DELAWARE

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: WICOMICO
10c. City, Town or Location: PITTSVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2353 PITTSVILLE - GUMBORO ROAD
10f. Zip Code: 21850
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): EARL CLINTON WELLS
18. Mother's Name (First, Middle, Maiden Surname): MILDRED JEANETTE SMITH

19a. Informant's Name/Relationship (Type, Print): CRYSTAL DAVIS / DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. BOX 106, PITTSVILLE, MARYLAND 21850

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): MILLSBORO CEMETERY
Date: 1/10/01
20c. Location - City or Town, State: MILLSBORO, DELAWARE

21. Signature of Funeral Service Licensee: Richard T. Watson
22. Name and Address of Facility: WATSON FUNERAL HOME, INC. 211 WASHINGTON STREET, MILLSBORO, DELAWARE 19966

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Ductal Carcinoma — mo

Due to (or as a consequence of):
b. Myocardial Ischemia — yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Coronary Artery Disease — yr

Due to (or as a consequence of):
d. Diabetes Mellitus — yr

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: 20441
29d. Date signed (Month, Day, Year): JANUARY 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Raffetto, M.D. 400 E. Shore Dr. Salisbury, MD 21801

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001
32. Registrar's Signature: Penny G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

222-30-2925

Division of Vital Records, P.O. Box 68760,

Juanita Savage

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01668

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Owen S. Swartzentruber

2. Date of Death Month Day Year: Jan. 4, 2001

3. Time of Death: 9:45 PM

4a. Facility Name *(If not institution, give street and number)*: 4202 Mason School Road

4b. City, Town, or Location of Death: Oakland

4c. County of Death: Garrett

Funeral Director

5. Social Security Number: 220-29-0705

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 12, 1927

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Garrett

10c. City, Town or Location: Oakland

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4202 Mason School Road

10f. Zip Code: 21550

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Farmer

16b. Kind of Business/Industry: Farming

17. Father's Name *(First, Middle, Last)*: Simon ----- Swartzentruber

18. Mother's Name *(First, Middle, Maiden Surname)*: Daisy ----- Yoder

19a. Informant's Name/Relationship *(Type, Print)*: Edna Swartzentruber/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4202 Mason School Road, Oakland, Md. 21550

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Slabaugh Cemetery

Date: 1/8/01

20c. Location - City or Town, State: Oakland, Maryland

21. Signature of Funeral Service Licensee: Bradley A. Stewart

22. Name and Address of Facility: Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. severe pulmonary interstitial fibrosis — yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: [X] 1 Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: [X] 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Donald R Richter MD

29c. License number: D30035

29d. Date signed *(Month, Day, Year)*: 01-05-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Donald R. Richter, M.D. 1533 Memorial Drive Oakland, MD 21550

State Registrar

31. Date filed *(Month, Day, Year)*: JAN - 8 2001

32. Registrar's Signature: Brenda D. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01669

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Marie Alice Sisler
2. Date of Death Month Day Year: January 15, 2001
3. Time of Death: 5:05 a.m.
4a. Facility Name *(If not institution, give street and number)*: Goodwill Mennonite Home
4b. City, Town, or Location of Death: Grantsville
4c. County of Death: Garrett

Funeral Director

5. Social Security Number: 218-64-8947
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 21, 1912
9. Birthplace *(State or Foreign Country)*: WV

Usual Residence of Decedent

10a. State: Maryland
10b. County: Garrett
10c. City, Town or Location: Friendsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3628 White Rock Road
10f. Zip Code: 21531
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married XX Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name *(First, Middle, Last)*: Tarleton T. Humberson
18. Mother's Name *(First, Middle, Maiden Surname)*: Alverta Frazee
19a. Informant's Name/Relationship *(Type, Print)*: Billy Ray Sisler/Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 20721 Garrett Highway, Oakland, Maryland 21550
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Blooming Rose Cemetery
Date: Jan. 18, 2001
20c. Location - City or Town, State: Friendsville, MD
21. Signature of Funeral Service Licensee: D. Lynn Newman
22. Name and Address of Facility: Newman Funeral Homes, P.A. P.O. Box 275; Grantsville, Maryland 21536

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. UREMIA — 36 Hours
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Old cerebral Infarct with hemiplegia
Diabetes Mellitus
Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: S. Chang M.D.
29c. License number: D25638
29d. Date signed *(Month, Day, Year)*: January 15, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SATURNINA CHANG, M.D. 10701 New Georges Creek S.W. Suite 3 - Frostburg Maryland 21532

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: S. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

5

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01670

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ethel Geneieve Shiner
2. Date of Death (Month, Day, Year): Jan. 13, 2001
3. Time of Death: 4:30 AM
4a. Facility Name (If not institution, give street and number): Garrett County Memorial Hospital
4b. City, Town, or Location of Death: Oakland
4c. County of Death: Garrett

Funeral Director

5. Social Security Number: 161-30-9679
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Sept. 26,1915
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Garrett
10c. City, Town or Location: Oakland
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 224 Kelley Drive
10f. Zip Code: 21550
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookkeeper
16b. Kind of Business/Industry: Public School System

17. Father's Name (First, Middle, Last): Orville ----- Wright
18. Mother's Name (First, Middle, Maiden Surname): Geneva ----- Winters

19a. Informant's Name/Relationship (Type, Print): Michael Kleppinger/Grandson
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 543 Pysel Crosscut Road, Oakland, Md. 21550

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Scarpelli Funeral Home
Date: 1/15/01
20c. Location - City or Town, State: Cumberland, Md.

21. Signature of Funeral Service Licensee: ▶ Franklin H. Custer
22. Name and Address of Facility: Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Acute Heart Failure	24 hours
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	Corpulmonale	3 years
Due to (or as a consequence of):		
c.	COPD	10 years
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: diverticulosis, FE deficiency anemia, osteoporosis

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Margaret Kaiser MD
29c. License number: D26650
29d. Date signed (Month, Day, Year): 1/13/2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Margaret A. Kaiser, MD, 13079 Garrett Highway, Oakland, MD 21550

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: ▶ Donna D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01671

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary J. Townsend

2. Date of Death (Month, Day, Year): January 1, 2001

3. Time of Death: 4:45 A.M.

4a. Facility Name *(If not institution, give street and number)*: 8642 George Washington Highway

4b. City, Town, or Location of Death: Oakland

4c. County of Death: Garrett

Funeral Director

5. Social Security Number: 242-34-1163

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 8, 1925

9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Garrett

10c. City, Town or Location: Oakland

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8642 George Washington Highway

10f. Zip Code: 21550

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 11th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Waitress

16b. Kind of Business/Industry: Restaurant

17. Father's Name *(First, Middle, Last)*: Harry ------ Reall

18. Mother's Name *(First, Middle, Meiden Surneme)*: Bessie ----- Hooten

19a. Informent's Name/Relationship *(Type, Print)*: Betty L. Kelly/Sister

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 8630 George Washington Hwy., Oakland, Md. 21550

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Bayard Cemetery

Date: 1/4/01

20c. Location - City or Town, State: Bayard, West Virginia

21. Signature of Funeral Service Licensee: Bradley N. Stewart

22. Name and Address of Facility: Stewart Funeral Home, 32 S. Second St., Oakland, Md. 21550

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Adenocarcinoma of Lung — 18 Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part ii. **Other signifikant conditiona** contributing to death but not resulting in the underlying cause given in Part i.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death *(Check only one)*: Hospital: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of injury *(Month, Dey Yeer)*

28b. Time of injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of Certifier: John Coghlin

29c. License number: D0033464

29d. Date signed *(Month, Dey, Yeer)*: 1/02/01

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print): Robert M. Coughlin, M.D. PO Box 8, Eglon, WV 26716

State Registrar

31. Date filed *(Month, Dey, Yeer)*: JAN - 4 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 01672

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John N. Wilson
2. Date of Death: Month January, Day 08, Year 2001
3. Time of Death: 1:30 A.M.
4a. Facility Name (If not institution, give street and number): VAMHCS FORT HOWARD DIVISION
4b. City, Town, or Location of Death: FORT HOWARD
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 710-10-9515
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 98 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): 03-18-02
9. Birthplace (State or Foreign Country): BALTIMORE, MD

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3503 Kentucky Avenue
10f. Zip Code: 21213
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired): Electrician
16b. Kind of Business/Industry: B G & E

17. Fathar's Nama (First, Middle, Last): George W. Wilson
18. Mother's Name (First, Middle, Maiden Surname): Alice Jane Rawls

19a. Informant's Neme/Reletionship (Type, Print): John F. Wilson (Son)
19b. Malling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code): 2405 Chatau Court, Fallston, Maryland 21047

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Most Holy Redeemer
Date: 1/11/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensea: Mark T. Zoe
22. Name and Address of Facility: Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Causa (Finat diseasa or condition resulting in death)
a. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco usa contributa to the causa of death? 1 [ ] Yas 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of ceusa of death? 1 [ ] Yas 2 [ ] No

25. Was case referred to medical examinar? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, straat, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner steted.
29b. Signature and title of certifier
29c. License number: D57239
29d. Date signed (Month, Dey, Year): January 08, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): SURESH SHANDELYA, M.D. 9600 NORTH POINT ROAD, FORT HOWARD, MD 21052

State Registrar

31. Date filed (Month, Dey, Year): JAN 10 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

WILSON, JOHN N.
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

13

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01673

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Stanley Zigmund Waskiewicz

2. Date of Death (Month, Day, Year): January 6, 2001

3. Time of Death: 10:20PM

4a. Facility Name *(If not Institution, give street and number)*: Upper Chesapeake Medical Center

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 217-46-0273

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 53 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 4, 1947

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Edgewood

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 108 Kennard Ave.

10f. Zip Code: 21040

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Painter

16b. Kind of Business/Industry: Automotive

17. Father's Name *(First, Middle, Last)*: Zigmund Stanley Waskiewicz

18. Mother's Name *(First, Middle, Maiden Surname)*: Wanda (nmn) Listick

19a. Informant's Name/Relationship *(Type, Print)*: Steven Waskiewicz / Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 208 E. Kingston Park Lane, Middle River, MD 21220

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hilltop Service Corp.

Date: 1-10-01

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Charles A. Engel

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Ventricular Fibrillation — 30 mins

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dilated cardiomyopathy.
Aortic Stenosis.
Chronic Obstructive lung disease

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: Attending

29c. License number: D-16444.

29d. Date signed *(Month, Day, Year)*: January 7-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VIJAY. S. NAIR M.D. 2112 Belair Road. Fallston. MD 21047

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001

32. Registrar's Signature: Anne B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Stanley. Waskiewicz BJ.

4+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01671

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MICHAEL ARTIS
2. Date of Death Month: JANUARY Day: 20 Year: 2001
3. Time of Death: 2:32 PM
4a. Facility Name *(If not institution, give street and number)*: MERCY MEDICAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Number: 212-50-0229
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 55 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: DEC. 03, 1945
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1719 WEST FAYETTE STREET
10f. Zip Code: 21223
10g. Citizen of What Country?: USA.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No. If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12TH GRADE. College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ASSEMBLER
16b. Kind of Business/Industry: GENERAL MOTORS

17. Father's Name *(First, Middle, Last)*: HARVIE ARTIS
18. Mother's Name *(First, Middle, Maiden Surname)*: MARGARET BEARD

19a. Informant's Name/Relationship *(Type, Print)*: JAMES ARTIS (BROTHER)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9421 SANDY CREEK RD. FT. WASH. MD. 20744

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MT. ZION CEMETERY. Date: 01-24-01
20c. Location - City or Town, State: LANSDOWNE, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ARRHYTHMIA — Minutes
Due to (or as a consequence of):
b. ACUTE RENAL FAILURE — Days
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Metastatic Adenocarcinoma — Months
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CROHN'S DISEASE, Hypertension, Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Marvin Lamar Bryant, Jr., MD
29c. License number: P133666
29d. Date signed *(Month, Day, Year)*: January 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LAMAR BRYANT, MD 22 SOUTH GREENE ST. BALTIMORE, MD 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

SHIP TO: SHEVLINS FUNERAL HOME 32 BARRACK STREET DUNDALK, IRELAND 011-353-42933-9796

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 01675

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
ROSS	ALLPORT	JANUARY 25 2001	08:02

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
THE JOHNS HOPKINS HOSPITAL	BALTIMORE	BALTIMORE CITY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
n/a	1☒M 2☐F	10 Yrs.			4/30/1990	Ireland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Ireland	Louth	Dundalk	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
Leinster View -Feede Mount Pleasant		Ireland

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
5th		student	student

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Philip Allport	Heather Dempster

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Philip Allport Father	leinsterView-Feede Mount Pleasant, Dundalk, Ireland

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☒Removal from State 4☐Donation 5☐Other (Specify)	Rose Lawn	1/30/01	Belfast, Ireland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Maria M. Zannino	Joseph N. Zannino Jr. Funeral HM 263 S.Conkling St., Baltimore, Maryland 21224

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode ot dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediete Cause (Finel disease or condition resulting in death)	a. CONGENITAL HEART DISEASE	10 YEARS
	Due to (or es a consequence ot):	
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or es e consequence of):	
	c.	
	Due to (or as a consequence ot):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause ot death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best ot my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title ot certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	RES-000	JANUARY 25 2001

30. Name and address ot person who completed cause of death (Item 23a) (Type, Print)
MICHAEL HOUSE THE JOHNS HOPKINS HOSPITAL 600 N. WOLFE ST BALTIMORE MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 25 2001	▶ Jenna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01676

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Betty Jean Bass
2. Date of Death: Month 1 Day 21 Year 2001
3. Time of Death: 8:25PM
4a. Facility Name (If not institution, give street and number): ST Agnes Healthcare 900 caton Ave
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 255-58-7068
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 7-27-1939
9. Birthplace (State or Foreign Country): Ga

Usual Residence of Decedent

10a. State: Md
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5106 Greenwich Avenue
10f. Zip Code: 21229
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Educational Assistant
16b. Kind of Business/Industry: Baltimore City Public Schools

17. Father's Name (First, Middle, Last): Charles Parker
18. Mother's Name (First, Middle, Maiden Surname): Claudia Mae Dotson

19a. Informant's Name/Relationship (Type, Print): Ronald Parker - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 400 N. Chester St Balto, Md 21231

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): King Mem Park
Date: 1/27/01
20c. Location - City or Town, State: Randallstown, Md

21. Signature of Funeral Service Licensee: John B. Johnson
22. Name and Address of Facility: March F. H. West 4300 Wabash Avenue Balto, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Respiratory Failure	5 days
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Bronchopneumonia	3 weeks
Due to (or as a consequence of):		
c.	Sepsis	3 weeks
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: David Dabb Patholoogist
29c. License number: D0056553
29d. Date signed (Month, Day, Year): 1/24/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 900 caton Ave Baltimore MD

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature: Jennie D Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28d-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 30 per FR,G792,02/01/01dhb

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01677

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LYNN T. BARBER
2. Date of Death (Month, Day, Year): JANUARY 16 2001
3. Time of Death: 11:41
4a. Facility Name (If not institution, give street and number): BON SECOURS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-07-6796
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 87 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 30, 1913
9. Birthplace (State or Foreign Country): SOUTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 914 WHITMORE AVENUE
10f. Zip Code: 21216
10g. Citizen of What Country?: USA.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): STEEL WORKER
16b. Kind of Business/Industry: BETHLEHEM STEEL

17. Father's Name (First, Middle, Last): WILLIAM T. BARBER
18. Mother's Name (First, Middle, Maiden Surname): MAMIE (MN-UNKNOWN)

19a. Informant's Name/Relationship (Type, Print): WINSLOW CARTER (SON)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 914 WHITMORE AVE., BALTIMORE, MD. 21216

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CROWNSVILLE CEMETERY Date: 01-23-01
20c. Location - City or Town, State: CROWNSVILLE, MARYLAND

21. Signature of Funeral Service Licensee: Luther W. Will
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD. 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — 10 MIN.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

CEREBROVASCULAR ACCIDENT

23b. Did tobacco use contributes to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner stated.

29b. Signature and title of certifier: S Amsel
29c. License number: D16347
29d. Date signed (Month, Day, Year): 1/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sheldon Amsel, M.D., 10000 Cathedral Street, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Patient known as: Iris Hortensia Bass

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01678

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Iris Hortensia		Bass	January 16, 2001	20:25

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sinai Hospital of Baltimore	Baltimore	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
229-80-2314	1☐ M 2☒ F XX	47 Yrs.			6-27-1953	Va

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	N/A	Baltimore	1☒ Yes 2☐ No XX

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4103 Springdale Avenue Apt C	21207	U S A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th grade	No	Lab Technician	Manufacturing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charlie Walton	Estelle Irene Watson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Estelle Walton	Rt 1 Box 34 C Meherria, Va 23954

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	New Bethel Baptist Ch	1-20-01	Meherrin, Va

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Wayne B Kite	March F/H West 4300 Wabash Avenue Baltimore, Md 21215

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Coagulopathy	1 month
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Multiple hemorrhagic strokes

Methicillin Resistant Staph Aureus Sepsis

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one)	
1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	RES-000	January 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brian Galbut, MD 2401 West Belvedere Baltimore, MD 21215

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 25 2001	▶ [signature] G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01679

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Norman Bach
2. Date of Death Month: January Day: 20 Year: 2001
3. Time of Death: 11:26 PM
4a. Facility Name (If not institution, give street end number): Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-10-0106
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3/24/14
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Glen Arm
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street end Number: 11507 Hannibal Road
10f. Zip Code: 21057
10g. Citizen of Whet Country?: USA

11. Maritel Stetus: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade | Collega (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter
16b. Kind of Business/Industry: Bethlehem Steel

17. Fethar's Nama (First, Middle, Last): Eugene E. Bach
18. Mother's Name (First, Middle, Maiden Surname): Rosie Hamill

19a. Informant's Name/Ralationship (Type, Print): Joyce VanArsdale Daughter
19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 11503 Hannibal Road Glen Arm, MD 21057

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Placa of Disposition (Neme of cemetery, crematory or other place): Metro Crematory, Inc.
Dete: 1/22/01
20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funeral Servica Licansee: Heather D. Hays
22. Name end Address of Facility: The Johnson Funeral Home, P.A. 8521 Loch Raven Blvd. Towson, MD 21286

Physician /Medical Examiner

23a. Part I. Enter tha disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset end Death)

Immediata Causa (Final disease or condition resulting in death): e. Hypoxemia
Due to (or es e consequence of):
Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated evants resulting in death) Lest:
b. Lung Cancer
Due to (or es a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Wes en autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings aveileble prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was cese refarred to medical examiner? 1 ☐ Yas 2 ☐ No

28. Placa of Death (Check only ona): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Othar (Specify)

27. Manner of Deeth: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Panding investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year): N/A
28b. Time of Injury: N/A M
28c. Injury at Work? 1 ☐ Yas 2 ☐ No
28d. Describe how injury occurred
28a. Piece of Injury - At homa, farm, street, factory, office building, etc. (Specify): N/A
28f. Location (Street and Number or Rurel Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1 ☑ Certifying Phyaician: To the best of my knowladga, daath occurred at the time, dete and place, end due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end plece, end dua to the cause(s) end manner stated.

29b. Signeture end title of certifier: Linda Lyndsay MD
29c. License number: P13454
29d. Date signed (Month, Dey, Yeer): January 20 2001

30. Name end addrass of person who completed ceusa of daath (Item 23a) (Type, Print): 5601 Loch Raven Blvd Baltimore Md 21239

State Registrar

31. Date filed (Month, Day, Yaar): JAN 25 2001
32. Registrer's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01680

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARIA CICCARONE
2. Date of Death: Month 01 Dey 23 Year 2001
3. Time of Death: 9:10PM
4a. Facility Name *(If not institution, give street and number)*: Joseph Richey Hospice
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 571-42-4018
6. Sex: 1☐M 2☒F
7. Age *(In yrs. last birthday)*: 66 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*:
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 912 Reverdy Road
10f. Zip Code: 21212
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Edward Ciccarone
18. Mother's Name *(First, Middle, Meiden Surname)*: UNK.

19a. Informant's Name/Relationship *(Type, Print)*: John Wacker/Executor
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 912 Reverdy Road Baltimore, MD 21212

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory Inc.
Date: 1-25-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediete Ceuse (Final disease or condition resulting in death)	a. BREAST CANCER, METASTATIC	7 YEARS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet Initieted events resulting in death) Lest	b.	
	Due to (or as e consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditione** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cauee of death? 1☐ Yee 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, and due to the ceuse(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: Douglas D. Ross MD
29c. License number: D0026327
29d. Date signed *(Month, Day, Year)*: 01-24-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DOUGLAS D. ROSS, 614 CAMPFIRE, COLUMBIA, MD 21045

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1-23-01 9:10 PM

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

MARIA CICCARONE

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #10b,C PER F.H. G791 1-25-01 WR

Certificate of Death

Reg. No. 2001 01681

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CURTIS DARDEN
2. Date of Death (Month, Day, Year): JANUARY 21, 2001
3. Time of Death: 9.50 P.M
4a. Facility Name (If not institution, give street and number): North ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 237-54-5092
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 1-03-36
9. Birthplace (State or Foreign Country): N. CAROLINA

Usual Residence of Decedent

10a. State: MD
10b. County: PG.
10c. City, Town or Location: ~~BALTO.~~ ADELPHI
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 2512 BUCK LODGE TERR
10f. Zip Code: 20783
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CHEF
16b. Kind of Business/Industry: RESTAURANT

17. Father's Name (First, Middle, Last): WILLIAM DARDEN
18. Mother's Name (First, Middle, Maiden Surname): ETHEL HINNANT

19a. Informant's Name/Relationship (Type, Print): DEBRA DARDEN
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2512 BUCK LODGE TERR. ADELPHI MD. 20783

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): WILSON CEMETERY
Date: 1-27-01
20c. Location - City or Town, State: CROFTON MD.

21. Signature of Funeral Service Licensee: ▶ Wesley Chavis
22. Name and Address of Facility: CHAVIS F.H. 2007 EASTERN AVE. BALTO. MD. 21231

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. UROSEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- CONGESTIVE HEART FAILURE
- H/O CEREBROVASCULAR ACCIDENT
- SEIZURES
- RENAL INSUFFICIENCY
- DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ MD
29c. License number: D51245
29d. Date signed (Month, Day, Year): JANUARY 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAJID SHARIF NORTH ARUNDEL HOSPITAL - Hospital Line - GLEN BURNIE MD 21061

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

CURTIS. DARDEN
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #5,7&8 PER FH G802 12/11/01 JH

Certificate of Death

Reg. No. 2001 01682

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lillian Rose Diedeman

2. Date of Death (Month, Day, Year): Jan. 20, 2001

3. Time of Death: 8:10 P.M.

4a. Facility Name (If not institution, give street and number): Noble House Nursing Home

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: ~~214-12-0344~~ 214-12-0341

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 ~~74~~ Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12/25/~~1926~~ 1911

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2327 N. Charles Street

10f. Zip Code: 21218

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12th Grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Office Manager

16b. Kind of Business/Industry: McCormick Co.

17. Father's Name (First, Middle, Last): Harry A. McCullum

18. Mother's Name (First, Middle, Maiden Surname): Lillian E. Kohlmar

19a. Informant's Name/Relationship (Type, Print): Ethel A. Lhamon

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4738 Shamrock Ave. Baltimore, MD 21206

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Metro Crematory, Inc.

Date: 1/25/01

20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: The Johnson Funeral Home, P.A. 8521 Loch Raven Blvd. Towson, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. Cerebrovascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, In my opinion, death occurred at the time, dete end pleca, end due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ C. Vergara-Soares MD

29c. License number: D 16619

29d. Date signed (Month, Day, Year): 1/23/01

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): C. Vergara-Soares 2327 N. Charles St. Baltimore, MD 21218

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001

32. Registrar's Signature ▶ Geneva G Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#24a perPHYG791 1/25/2001 EW

Certificate of Death

Reg. No. 2001 01683

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MICHAEL EICHHORN
2. Date of Death (Month, Day, Year): JANUARY 15 2001
3. Time of Death: 13:45
4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 100-07-7063
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 12, 1910
9. Birthplace (State or Foreign Country): Rumania

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6401 Loch Raven Blvd #502
10f. Zip Code: 21239
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unk; College (1-4or 5+): unk
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): barber
16b. Kind of Business/Industry: cosmotology

17. Father's Name (First, Middle, Last): Anton Eichhorn
18. Mother's Name (First, Middle, Maiden Surname): Anna Jacob

19a. Informant's Name/Relationship (Type, Print): Betty Setzer/niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2905 Pinewood Avenue Baltimore, MD 21214

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Myocardial Infarction	
Due to (or as a consequence of):	b. Pneumonia.	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD.
29c. License number: P-13456
29d. Date signed (Month, Day, Year): January 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LUISA MUNOZ, 6920 Donachie Rd Apt 1609, BALTIMORE, MD 21239

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 01684

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Denise Evans
2. Date of Death: Month January Day 22 Year 2001
3. Time of Death: 0124
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 219-70-0462
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 44 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4-7-56
9. Birthplace (State or Foreign Country): BALTO

Usual Residence of Decedent

10a. State: Md.
10b. County:
10c. City, Town or Location: BALTO.
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 3 N. Clinton st.
10f. Zip Code: 21224
10g. Citizen of What Country? U.S.A.
11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMAKER
16b. Kind of Business/Industry: HOME
17. Father's Name (First, Middle, Last): NORMAN EVANS
18. Mother's Name (First, Middle, Maiden Surname): CORA EVANS
19a. Interment's Name/Reletionship (Type, Print): ROSENA SALISBURY
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3212 LEVERTON AVE BALTO. MD. 21224
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Voshell Date: 2-02-01
20c. Location - City or Town, State: BALTO. MD.
21. Signature of Funeral Service Licensee: Wesley Chavis
22. Name and Address of Facility: Chavis F. H. 2007 Eastern Ave Balto. Md. 21231

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. renal failure — days
Due to (or as a consequence of):
b. pneumonia — days
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. cardiomyopathy — years
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Antonia Bunce, MD
29c. License number: 20300
29d. Date signed (Month, Day, Year): January 22, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Antonia Bunce 4940 Eastern Avenue Baltimore 21224

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature:

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01685

Amended Item #3 25,26,27 perPHYg791 1/25/2001 EW

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Data of Death Month / Day / Yaar	3. Tima of Death
CHARLES	ECKSTEIN	JANUARY 14 2001	12:35 pm

4a. Facility Nama (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Johns Hopkins Hospital	Baltimore City	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Aga (In yrs. last birthday)	If Under 1 Yaer: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-30-5688	1☒ M 2☐ F	67 Yrs.			April 7,1933	Maryland

Usual Rasidance of Decedent

10a. Stata	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Dundalk	1☐ Yas 2☒ No

10e. Street and Number	10f. Zip Coda	10g. Citizen of What Country?
865 Loalan Ave.	21222	United States

11. Meritel Stetus	12. Was Decedant Evar in U.S. Armed Forces?	13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.)	14. Race - American Indian, Black, White, atc.
1☐ Nevar Marriad 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yas 2☐ No If Yas, Giva Year or Datas: Korean	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grada completed)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	Collega (1-4or 5+)		
7 Years		Crane Operator	Steel Industry

17. Fathar's Nama (First, Middla, Last)	18. Mother's Nama (First, Middle, Maidan Sumama)
Henry William Eckstein	Ethel May Hauer

19a. Informant's Name/Retetionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code)
Mrs. Elaine J. Eckstein (Wife)	865 Loalan Ave. Dundalk, Maryland 21222

20a. Method of Disposition	20b. Placa of Disposition (Nama of cemetery, cramatory or other place)	Data	20c. Location - City or Town, State
1☐ Burial 2☒ Cramation 3☐ Ramovel from Stata 4☐ Donation 5☐ Othar (Specify)	Hilltop Service Corp.	1/18/2001	Towson, Maryland

21. Signature of Funaral Service Licansee	22. Nama and Address of Facility
▶ D. C. Caudl	Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complicetions that causad tha death. Do not antar tha moda of dying, such as cardiac or raspiratory errast, shock, or haart failure. List only ona causa on each line.

		Approximate Interval Between Onsat and Death
Immediate Ceuse (Final diseese or condition resulting in death)	a. SEPSIS	6 DAYS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Disease or injury that initiated evants resulting in death) Last	b.	
	Due to (or as a consequenca of):	
	c.	
	Due to (or as a consequanca of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa givan in Part I.

PANCREATITIS

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Ware autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown	1☒ Yas 2☐ No	1☐ Yas 2☒ No

25. Was casa refarrad to medical examinar?	26. Place of Death (Check only ona)	
1☐ Yas 2☒ No	Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Rasidanca 6☐ Othar (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined		M	1☐ Yas 2☐ No	
	28e. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)			28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifiar (Check only one) 1☐ **Certifying Physician**: To tha best of my knowledge, death occurred at tha tima, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, daath occurred at tha tima, data and placa, and dua to the cause(s) and manner stated.

29b. Signeture and title of certifier	29c. Licensa number	29d. Data signed (Month, Day, Year)
▶ Shai Rozen, M.D.	RES-000	JANUARY 14, 2001

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print)

SHAI ROZEN 600 NORTH WOLFE ST., BALTIMORE, MD 21287-9106

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signatura
JAN 25 2001	▶ Denise G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01686

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOHN FEHIR

2. Date of Death Month: January Day: 16 Year: 2001

3. Time of Death: 10:02am

4a. Facility Name *(If not institution, give street and number)*: UNIVERSITY OF MARYLAND MEDICAL SYSTEM

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Number: 335-14-8883

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept 22, 1922

9. Birthplace *(State or Foreign Country)*: unk

Usual Residence of Decedent

10e. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 524 N. Charles Street

10f. Zip Code: 21201

10g. Citizen of What Country?: USA

11. Marital Status: unk
1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No unk
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc.
Specify: white

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondery (0-12): unk
College (1-4or 5+): unk

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: unk

16b. Kind of Business/Industry: unk

17. Father's Name *(First, Middle, Last)*: unk

18. Mother's Name *(First, Middle, Maiden Surname)*: unk

19a. Informant's Neme/Relationship *(Type, Print)*: UMMS

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 22 N. Green Street Baltimore, MD 21201

20e. Method of Disposition
1☐ Burial 2☐ Cremation 3☐ Removei from State
4☐ Donetion 5☒ Other *(Specify)* in state

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*:

Date:

20c. Location - City or Town, State:

21. Signeture of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Partl. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heert feilure. List only one cause on each line.

Approximate Interval Between Onset and Deeth

Immediate Ceuse (Final diseese or condition resulting in death)
a. Myocardial Infarction.

Due to (or as e consequence of):
b. Pulmonary Embolism

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Due to (or es e consequence of):
c.

Due to (or es a consequence of):
d.

Part II. **Other signifkant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Was en autopsy performed?
1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No

25. Was case referred to medical examiner?
1☐ Yes 2☒ No

26. Place of Death *(Check only one)*
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*:

28b. Time of Injury M:

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred:

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*:

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*:

29a. Certifier *(Check only one)*
1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) end menner steted.

29b. Signature and title of certifier: MD

29c. License number: U13115

29d. Date signed *(Month, Day, Year)*: January 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LANCE URADOMO, 22 S. GREENE ST BALTIMORE MD 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001

32. Registrar's Signature: Jenna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01687

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SARAH FERGUSON
2. Date of Death Month / Day / Year: JANUARY 24 2001
3. Time of Death: 1:05A
4a. Facility Name *(If not institution, give street and number)*: Bon Secour Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-22-4443
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 09-13-1921
9. Birthplace *(State or Foreign Country)*: South Carolina

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No XX
10e. Street and Number: 208 Oak Leaf Way
10f. Zip Code: 21227
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaer or Detas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondery (0-12): 12 th; College (1-4or 5+): 2
16a. Decedent's Usuel Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Clerk
16b. Kind of Business/Industry: Winthrop College

17. Father's Nema *(First, Middla, Last)*: Richard Burns
18. Mother's Neme *(First, Middle, Meiden Sumema)*: Jesse Collins

19a. Informent's Neme/Reletionship *(Type, Print)*: Ruth B. Caldwell (Daughter)
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 208 Oak Leaf Way Balto., Md. 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Grandview Memorial Pk.
Date: 1/29/01
20c. Location - City or Town, State: Rock Hill South Carolin

21. Signature of Funeral Service Licensee: Dennis B. Caple
22. Name end Address of Feciliby: Dennis B. Caple Funeral Home 4601 York Rd. Balto., Md. 21212

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

		Approximete Interval Between Onsat end Daath
Immediate Cause (Final diseese or condition resulting in death) a.	PNUEMONIA with SEPSIS	14 DAYS
Due to (or as a consequence of): b.	CONGESTIVE HEART FAILURE	10 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest — Due to (or es e consequence of): c.	RENAL FAILURE	UNKNOWN
Due to (or es e consequenca of): d.	ARTERIOSCLEROTIC HEART DISEASE	11

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- HYPERTENTION
- DIABETES MELLITUS
- CEREBROVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, deta end place, and dua to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) and mannar steted.

29b. Signatura and title of certifier: M.D.
29c. License number: D 23300
29d. Data signad *(Month, Day, Year)*: JANUARY 24 2001

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): SUDHIR. D. PATEL BON SECOURS HOSP. 2000 W. BALTO. ST. BAL. MD. 21223

State Registry

31. Dete filed *(Month, Dey, Year)*: JAN 25 2001
32. Registrer's Signeture:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01688

KENNETH FUNK SR.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KENNETH JEROME FUNK, SR.
2. Date of Death (Month, Day, Year): January 23 2001
3. Time of Death: 6:00 P.M.
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL ASSOCIATION
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 212-20-9036
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 75 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 7, 1925
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 33 CHESTER CIRCLE
10f. Zip Code: 21060
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1944-46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [■] No Specify:
14. Race - American Indian, Black, White, etc. Specify:

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SUPERVISOR
16b. Kind of Business/Industry: CSX

17. Father's Name (First, Middle, Last): GEORGE FUNK
18. Mother's Name (First, Middle, Maiden Surname): BERNICE FERREE

19a. Informant's Name/Relationship (Type, Print): MRS. AUDREY FUNK (WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 33 CHESTER CIRCLE, GLEN BURNIE, MD. 21060

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GLEN HAVEN MEMORIAL PARK
Date: 1/27/2001
20c. Location - City or Town, State: GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GELN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Prostatic cancer	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D43977
29d. Date signed (Month, Day, Year): January 23 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ayesha Rasul 301 Hospital Drive, Glen Burnie MD. 21061.

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature: [signature] Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended item#23a perPHYG791 1/25/01 EW

Certificate of Death

Reg. No. 2001 01689

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death (Month, Day, Year)	3. Time of Death
ELAINE	FRIEDLANDER	JANUARY 15, 2001	7:10 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
JEWISH CONVALESCENT HOME	BALTIMORE	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-34-2294	1☐ M 2☒ F	70 Yrs.			MAR.28,1930	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	BALTIMORE	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7920 SCOTTS LEVEL ROAD	21208	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
LOUIS	FRIEDLANDER	ROSE	MASLOW

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
FRANCES ZYWICA / SISTER	3622 FORDS LANE #D - BALTIMORE, MD 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	SHEARITH ISRAEL CEMETERY	1/16/01	BALTIMORE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Jay Wm Zywica	SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Asphyxiation	10 min
Due to (or as a consequence of):	b. ~~Aspiration~~ TERMINAL ASPIRATION	10 min
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Epilepsy	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Elliot Rothschild MD	051426	Jan. 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elliot Rothschild, 4000 Old Court, Pikesville

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 25 2001	▶ Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01690

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DENNIS WESLEY FUNK
2. Date of Death (Month, Day, Year): JANUARY 22 2001
3. Time of Death: 4:40 pm
4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 213-68-9147
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 45 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4/29/1955
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Chase
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 139 Rodeo Circle
10f. Zip Code: 21220
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter
16b. Kind of Business/Industry: Self Employed

17. Father's Name (First, Middle, Last): Daniel Calvin Funk
18. Mother's Name (First, Middle, Maiden Surname): Doris Otter

19a. Informant's Name/Relationship (Type, Print): Daniel Funk
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4518 Hazelwood Avenue Baltimore, Maryland 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Crownsville VA Cemetery
Date: 1/26/01
20c. Location - City or Town, State: Crownsville, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. RESPIRATORY FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. PNEUMONIA WITH SEPSIS

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Petronella Adomako MD
29c. License number: P 14416
29d. Date signed (Month, Day, Year): JANUARY 22 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): PETRONELLA ADOMAKO GOOD SAMARITAN HOSPITAL; 5601 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21239

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01691

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ANNA FRAGALE

2. Date of Death — Month: 1 Day: 21 Year: 2001

3. Time of Death: 2:45 PM

4a. Facility Name *(If not institution, give street and number)*: John Hopkins Bayview Nursing Home

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-28-6481

6. Sex: 1☐ M 2☑ F

7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 7, 1920

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 131 N. Collington Avenue

10f. Zip Code: 21231

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 4th — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Janitorial

16b. Kind of Business/Industry: Government

17. Father's Name *(First, Middle, Last)*: Simon Buzgierski

18. Mother's Name *(First, Middle, Maiden Surname)*: Catherine Orlowska

19a. Informant's Name/Relationship *(Type, Print)*: Rose Jerousek/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 131 N. Collington Avenue Baltimore, Maryland 21231

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Stanislaus Cemetery

Date: 1/24/01

20c. Location - City or Town, State: Baltimore

21. Signature of Funeral Service Licensee: Thomas J. Skuda Jr.

22. Name and Address of Facility: David J. Weber Funeral Homes, P.A. 401 S. Chester St. Baltimore, Maryland 21231

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pancreatic cancer — 2 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D37089

29d. Date signed *(Month, Day, Year)*: 12201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BRUCE LEFT MD. JOHNS HOPKINS BAYVIEW IR BALTIMORE MD 21224

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001

32. Registrar's Signature: Geneva G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01692

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ALVIN M. FORD

2. Date of Death (Month, Day, Year): JANUARY 20, 2001

3. Time of Death: 12:45PM

4a. Facility Name *(If not institution, give street and number)*: JEWISH CONVALESCENT & NURSING HOME

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-01-8064

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: DEC.14,1914

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 7920 SCOTTS LEVEL ROAD

10f. Zip Code: 21208

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yas, Giva Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - Amarican Indian, Black, Whita, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedant's Usual Occupation *(Give kind of work done during most of working life. DO NOT usa retired)*: SALESMAN

16b. Kind of Business/Industry: AUTOMOTIVE

17. Father's Name *(First, Middle, Last)*: MOSES FORD

18. Mother's Name *(First, Middle, Maidan Surname)*: SADYE SONNER

19a. Informant's Name/Reletionship *(Type, Print)*: MARY JO DALE / DAUGHTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 29 NORTH ANN STREET - BALTIMORE, MD 21231

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: HILLTOP SERVICE CORP.

Date: 1/23/01

20c. Location - City or Town, State: TOWSON, MD

21. Signature of Funeral Service Licensee: Scott M. Cottle

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrast, shock, or heart failure. List only one cause on eech line.

Approximate Interval Batween Onset end Death

Immediete Ceusa (Final disease or condition resulting in deeth)

a. CEREBRAL THROMBOSIS — MINUTES

Dua to (or as a consequance of):

Sequentially list conditions, if eny, leading to immediete ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings availeble prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Wes case referred to medical examinar? 1 [ ] Yes 2 [✓] No

26. Piece of Deeth *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [✓] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Menner of Death: 1 [✓] Naturel 2 [ ] Accident 3 [ ] Sulcide 4 [ ] Homicide 5 [ ] Pending invastigetion 6 [ ] Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, Steta)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to tha causa(s) and mannar es stated. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and placa, and dua to tha causa(s) and menner steted.

29b. Signeture end title of certifier: Deborah A Pierce

29c. License number: 145931

29d. Data signed *(Month, Dey, Year)*: January 23, 2001

30. Name end eddress of parson who completed causa of deeth (item 23e) (Type, Print): Deborah Pierce 7220 Park Heights Avenue Baltimore MD 21208

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 25 2001

32. Registrar's Signetura: Geneva G Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item 20b per FH,G791,01/25/01dhb

Certificate of Death

Reg. No. 2001 01693

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
RUTH	FLOWE	JANUARY 20, 2001	9:32 pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Johns Hopkins Hospital	Baltimore City	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
230-16-3082	1☐ M 2☒ F	78 Yrs.			JUNE 20, 1922	N. CAROLINA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	N/A	BALTIMORE	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
911 E. BONAPARTE AVENUE	21218	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	AFRO-AMERICAN Specify:

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12th		HOME HEALTH NURSE	SELF-EMPLOYED

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
LUTHER ALEXANDER	JANIE FORESTER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ROBERT ALEXANDER (SON)	BOX 40 Orangeburg, NEW YORK, N.Y. 10962

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	MT. ZION CEM.	JAN. 26, 2001	BALTO, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Bernadine V. Scruggs	CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CORONARY ARTERY DISEASE	HOURS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. HYPERTENSION	YEARS
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Gary Green MD	D0037658	JANUARY 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gary Green MD 600 North Wolfe St. Baltimore, MD 21287

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 25 2001	Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

JAN 2 5 2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01694

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Paul Gordon
2. Date of Death (Month, Day, Year): Jan. 11, 2001
3. Time of Death: 9:40AM
4e. Facility Name (If not institution, give street and number): Mariner Health
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-84-9046
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 15, 1905
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5721 Grosvenor Lane
10f. Zip Code: 20814
10g. Citizen of What Country: USA

11. Marital Status: unk — 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? unk — 1☐ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) — 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. — Specify: black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): unk
College (1-4or 5+): unk
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk
16b. Kind of Business/Industry: unk

17. Father's Name (First, Middle, Last): unk
18. Mother's Name (First, Middle, Maiden Surname): unk

19a. Informent's Name/Relationship (Type, Print): Mareint Health of Bethesda
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 5721 Grosvenor Lane Bethesda, MD 20817

20a. Method of Disposition: 1☐ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) in state
20b. Place of Disposition (Name of cemetery, cremetory or other place)
Dete
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Cancer, Primary Unknown — not known

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last
b.

Due to (or as e consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco uee contribute to the cauee of death? 1☐ Yee 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred et the time, date and place, and dua to the ceuse(s) and manner stated.

29b. Signature end title of certifier: David A. Blass M.D.
29c. License number: D23911
29d. Date signed (Mohth, Day, Year): January 16, 2001

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print): David A. Blass, M.D. 9410 Old Georgetown Road, Bethesda, Maryland 20814

State Registrar

31. Dete filed (Month, Dey, Year): JAN 25 2001
32. Registrar's Signature: Jennie G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01695

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY I GREGORY

2. Date of Death — Month: JANUARY Day: 20 Year: 2001

3. Time of Death: 7:15 AM

4a. Facility Name *(If not institution, give street and number)*: Saint Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 212-22-2019

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 99 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: Sept 25, 1901

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 711 Academy Road

10f. Zip Code: 21228

10g. Citizen of What Country?: USA

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest greda complated)*: Elementary/Secondary (0-12): 8 College (1-4 or 5+): 0

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: cake decorator

16b. Kind of Business/Industry: bakery

17. Father's Neme *(First, Middle, Last)*: Christopher Cliffe

18. Mother's Neme *(First, Middle, Maiden Sumame)*: unk

19a. Informant's Neme/Reletionship *(Type, Print)*: John Gregory/son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 274 Winterberry Lane Westminster, MD 21157

20a. Method of Disposition: 1☐ Burial 2☐ Cramation 3☐ Removal from State 4☒ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*:

Dete:

20c. Location - City or Town, Stete:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Nama and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel diseese or condition resulting in death) a.	Sepsis	7 days
Due to (or es a consequence of):		
Sequentially list conditions, if any, leading to immedeate cause. Enter Underlying Ceuse (Diseese or injury that initiated avents resulting in death) Lest b.	Pneumania	7 days
Due to (or as e consequence of):		
c.		
Dua to (or as a consequance of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*:

28b. Time of Injury:

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred:

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*:

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*:

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, data and piece, and due to the cause(s) and menner stated.

29b. Signeture and title of certifiar: George Durst MD

29c. Licanse number: P14442

29d. Date signed *(Month, Dey, Year)*: JANUARY 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GEORGE DURST, M.D. 900 CATON AVENUE BALTIMORE, MARYLAND 21229

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001

32. Registrer's Signeture: Jeanne G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

NAME MARY GREGORY

RELEASE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01696

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Linwood Austin Gray

2. Date of Death: Month JANUARY Day 23, Year 2001

3. Time of Death: 12 35 AM

4a. Facility Name (If not institution, give street and number): Stella Maris at Mercy Hospice

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 004-30-9919

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV 17, 1932

9. Birthplace (State or Foreign Country): Maine

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 204 Ferndale Avenue

10f. Zip Code: 21061

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1951-1954

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Food Service

16b. Kind of Business/Industry: Warehouse

17. Father's Name (First, Middle, Last): Carl S. Gray

18. Mother's Name (First, Middle, Maiden Surname): Thelma M. Garnett

19a. Informant's Name/Relationship (Type, Print): Kathleen E. Beall/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1014 Glenvilla Drive Glen Burnie, MD 21061

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.

Date: 1-23-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregotchik

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Parkinsons Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) STELLA MARIS AT MERCY HOSPICE

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dr [illegible]

29c. License number: D 40854

29d. Date signed (Month, Day, Year): JANUARY 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St Paul Pl BALTIMORE MD 21202

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001

32. Registrar's Signature: Jeanne G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01697

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Samuel George Greenwood

2. Date of Death (Month, Day, Year): JAN 25, 2001

3. Time of Death: 7:30am

4a. Facility Name *(If not institution, give street and number)*: 4304 Quigley Place

4b. City, Town, or Location of Death: Marlow Heights

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 101-16-9755

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: NOV. 6, 1925

9. Birthplace *(State or Foreign Country)*: Canada

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Marlow Heights

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4304 Quigley Place

10f. Zip Code: 20748

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1944-1952

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Carpenter

16b. Kind of Business/Industry: Home Improvement

17. Father's Name *(First, Middle, Last)*: Samuel Albert Greenwood

18. Mother's Name *(First, Middle, Maiden Surname)*: Kathleen Gertrude Armstrong

19a. Intormant's Name/Relationship *(Type, Pnnt)*: Gladys Marie Greenwood/wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4304 Quigley Place Marlow Heights, MD 20748

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory, Inc.

Date: 1/26/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald

Dawn F. McDonald

22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceusad the death. Do not enter the mode ot dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ona cause on each line.

Approximate Interval Between Onset and Death

Immediata Cause (Final disease or condition resulting in death)

a. Prostate Cancer — 7 years

Due to (or as a consequence ot):

Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence ot):

c.

Due to (or as a consequence ot):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yas 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yas 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner ot Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician**: To the best ot my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Harvey Katzen

29c. License number: D20352

29d. Date signed *(Month, Day, Year)*: 1/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Harvey Katzen 8926 Woodyard Rd #201 Clinton MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #7 PER F.H. G791 1-25-01 WR.

Certificate of Death

Reg. No. 2001 01698

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EMMA GREENWALD
2. Date of Death: Month 01 Day 23 Year 2001
3. Time of Death: 10:23 AM
4e. Facility Name (If not institution, give street and number): Stella Maris
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-05-3326
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): ~~96~~ 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 28 1905
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Street
10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 845 Federal Hill Rd.
10f. Zip Code: 21154
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): n/a
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookkeeper
16b. Kind of Business/Industry: Accounting

17. Father's Name (First, Middle, Last): Louis Berends
18. Mother's Name (First, Middle, Maiden Surname): Fredericka Broghammer

19a. Informant's Name/Relationship (Type, Print): Debra Rudd/great niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 845 Federal Hill Rd., Street, MD 21154

20a. Method of Disposition: ☒ 1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Moreland Memorial Park
Date: 1/26/01
20c. Location - City or Town, State: Hillendale, MD

21. Signature of Funeral Service Licensee: Bryan W. Clary
22. Name and Address of Facility: Lemmon Funeral Home, 10 W. Padonia Rd., Timonium, MD 21093

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. End Stage Dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D43725
29d. Date signed (Month, Day, Year): 1/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TARIQ MAHMOOD 201-109 Back River Neck Rd Baltimore 21221

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

GREENWALD, EMMA
Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 01699

Gunzelman, Robert 1-19-01 430p

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROBERT JOSEPH GUNZELMAN
2. Date of Death Month / Day / Year: January 19, 2001
3. Time of Death: 4:30 P.M.
4a. Facility Name *(If not institution, give street and number)*: Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-28-1825
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 69 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 10, 1931
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Owings Mills
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 5 Pleasant Ridge Drive apt.109
10f. Zip Code: 21117
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2 years
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales
16b. Kind of Business/Industry: Department Store

17. Father's Name *(First, Middle, Last)*: Charles Gunzelman
18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Garrish

19a. Informant's Name/Relationship *(Type, Print)*: Harriet Gunzelman (wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5 Pleasant Ridge Drive Apt. 109 Owings Mills, MD 21117

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dulaney Valley Memorial Gardens
Date: 1-22-01
20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: George J. Feeman
22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CVA — weeks

Due to (or as a consequence of):
b. Burkitt's-like Lymphoma — months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Ischemic cardiomyopathy

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D0051926
29d. Date signed *(Month, Day, Year)*: Jan 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Helen M. Gordan 6565 N. Charles St Baltimore MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001
32. Registrar's Signature: James G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

For Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01700

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPH GEORGE HOPP

2. Date of Death (Month, Day, Year): JANUARY 23, 2001

3. Time of Death: 6:40PM

4a. Facility Name (If not institution, give street and number): FUTURE CARE CHERRYWOOD NURSING HOME

4b. City, Town, or Location of Death: REISTERSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 217-09-3375

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 2-2-1916

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: CARROLL

10c. City, Town or Location: WESTMINSTER

10d. Inside City Limits: 1 [ ] Yes [X] No

10e. Street and Number: 641 HOOK ROAD

10f. Zip Code: 21157

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TRUCK DRIVER

16b. Kind of Business/Industry: CONTINENTAL CAN

17. Father's Name (First, Middle, Last): WILLIAM HOPP

18. Mother's Name (First, Middle, Maiden Surname): WILHELMINA MARKET

19a. Informant's Name/Relationship (Type, Print): LINDA ZELENKA (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 641 HOOK ROAD WESTMINSTER, MD 21157

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): HOLY REDEEMER CEMETERY

Date: 1/26-01

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE, MD 21237

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC CEREBROVASCULAR

Due to (or as a consequence of): DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: END STAGE DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D28595

29d. Date signed (Month, Day, Year): 1/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TASNEEM LAKHANI, 7220 PARK HEIGHTS AVE, BALTO MD 21208

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01701

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Martha Mattoon Hastings
2. Date of Death (Month, Day, Year): January 23, 2001
3. Time of Death: 8:00 PM
4a. Facility Name *(If not institution, give street and number)*: Future Care Chesapeake
4b. City, Town, or Location of Death: Arnold
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 578-42-9250
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JULY 1, 1913
9. Birthplace *(State or Foreign Country)*: Washington DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Arnold
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 305 College Parkway
10f. Zip Code: 21012
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 5 +
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher
16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: Wilbur Reed Mattoon
18. Mother's Name *(First, Middle, Maiden Surname)*: Catherine VanLiew

19a. Informant's Name/Relationship *(Type, Print)*: Alice C. Hastings/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1576 Marco Drive Pasadena, MD 21122

20a. Method of Disposition: 1☐ Buriel 2☒ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, cremetory or other piece)*: Metro Crematory Inc.
Date: 1-24-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregor
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. chronic obstructive pulmanary disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: congestive heart failure, diabetes, coronary artery disease, atrial fibrillation, herpes zoster, renal insufficiency

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete end placa, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner**: On the basis of exemination end/or investigetion, in my opinlon, deeth occurred et the time, date end placa, snd due to the cause(s) and menner steted.

29b. Signature and title of certifier: [signature]
29c. License number: D41955
29d. Date signed *(Month, Day, Year)*: 1-24-01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Rebecca Jon MD 479 Tumpers Hole Rd Severna Park MD 21146

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 25 2001
32. Registrer's Signeture: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item #24a per PHYG791 1/25/2001 EW

Certificate of Death

Reg. No. 2001 01702

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John H. Harley

2. Date of Death (Month, Day, Year): January 10, 2001

3. Time of Death: 930 pm

4a. Facility Name (If not institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: NA

Funeral Director

5. Social Security Number: 057-12-2784

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 01-30-12

9. Birthplace (State or Foreign Country): SC

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: [X] Yes 2 [ ] No

10e. Street and Number: 1213 Light Street

10f. Zip Code: 21230

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 12th Grade

College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Musician

16b. Kind of Business/Industry: Musician

17. Father's Name (First, Middle, Last): Norman Harley

18. Mother's Name (First, Middle, Maiden Surname): Sarah Cooke

19a. Informent's Neme/Reletionship (Type, Print): Andre Harley

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1579 Crescent Avenue Teaneck, N.J. 07666

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Cemetery

Date: 01-13-2001

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Jean C Gantz

22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

John Harley

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death): e. Cardiomyopathy

Due to (or as e consequence of): b. Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings availeble prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) end menner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Nduaguba MD

29c. License number: P 14582

29d. Date signed (Month, Day, Year): 1/11/01

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print): Constance Nduaguba, M.D. c/o Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001

32. Registrar's Signature: Jeanne G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01703

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BEATRICE I. HERSHEY

2. Date of Death (Month, Day, Year): January 22 2001

3. Time of Death: 5:40 P.m.

4a. Facility Name (If not institution, give street and number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 175-18-9849

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG. 14, 1920

9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 102 JUNIPER DRIVE

10f. Zip Code: 21060

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elamentary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): WILLIAM THOMAS

18. Mother's Name (First, Middle, Maiden Surname): MARTHA P. HARDEN

19a. Informant's Name/Relationship (Type, Print): ROBERT H. HERSHEY (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 102 JUNIPER DRIVE, GLEN BURNIE, MARYLAND 21060

20a. Method of Disposition: ☒1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, cremetory or other place): MARYLAND VETERANS CEMETERY Date: 01/26/2001

20c. Location - City or Town, State: CROWNSVILLE, MD.

21. Signature of Funeral Service Licensee: Paul A. Hagan

22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. SEPTICEMIA

Due to (or as a consequence of):

b. ISCHEMIC BOWEL

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. ACUTE RENAL FAILURE

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, offica building, atc. (Specify)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Data of Injury (Month, Day Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, daeth occurred at tha time, deta and place, end due to tha ceuse(s) and menner es stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, In my opinion, daath occurred at the time, date and place, and dua to the cause(s) end manner steted.

29b. Signatura and title of certifier: MD

29c. Licanse number: D43477

29d. Data signed (Month, Day, Year): January 22 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Anpka Dhatinja 301 Hospital Drive Glen Burnie MD 21061

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001

32. Registrar's Signature: Emma L Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

BEATRICE HERSHEY

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01704

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Stanley Levere Hare
2. Date of Death (Month, Day, Year): January 23, 2001
3. Time of Death: 10:00 p.m.
4a. Facility Name (If not institution, give street and number): Carroll County General Hospital
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 218-07-3930
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Yeer: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 1, 1916
9. Birthplace (State or Foreign Country): Millers, Md.

Usual Residence of Decedent

10a. Stete: Md.
10b. County: Carroll
10c. City, Town or Location: Hampstead
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4000 Maple Grove Road
10f. Zip Code: 21074
10g. Citizen of What Country?: U.S.A.

11. Merital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Detes: W.W.II
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Rece - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Suburban Propane Co.
16b. Kind of Business/Industry: Gas/Fuel

17. Father's Name (First, Middle, Last): Howard Franklin Hare
18. Mother's Neme (First, Middle, Maiden Sumeme): Delilah Richarts

19a. Informent's Neme/Reletionship (Type, Print): Hildred Hare - wife
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 4000 Maple Grove Road Hampstead, Md. 21074

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Lineboro Cemetery
Dete: Jan. 27, 2001
20c. Location - City or Town, Steta: Lineboro, Md.

21. Signeture of Funeral Service Licensee: Justin R. Eckhardt
22. Neme end Address of Facility: Eckhardt Funeral Chapel, P.A. 3296 Charmil Dr. Manchester, Md. 21102

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Deeth

Immediate Ceuse (Finel disease or condition resulting in death): a. Probable pulmonary embolus
Due to (or es e consequence of):
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Malignant lymphoma

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings availebla prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Deeth (Check only one): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Othar (Specify)
27. Menner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end manner as steted. 2 [ ] **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete and place, end due to the cause(s) and menner steted.

29b. Signeture end title of certifier: Howard Saintz, M.D.
29c. License number: Md. # D15552
29d. Dete signed (Month, Day, Year): 1/29/01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Howard Saintz, M.D. 555 S. Center St. Westminster, Md.

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 25 2001
32. Registrer's Signeture: Donna B. Sprecher

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-0340-510
crn
Unknown 01-017
Johnnie Jenkins

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01705

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHNIE WOODS JENKINS JR.

2. Date of Death (Month, Day, Year): January 21, 2001

3. Time of Death: 1:36 A.M.

4s. Facility Name (If not institution, give street and number): 1400 Block of Barnes Street

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-92-8143

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 32 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): FEB. 26, 1968

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street snd Number: 424 TUXEDO STREET

10f. Zip Code: 21211

10g. Citizen of Whst Country?: USA

11. Merital Status: 1 [X] Never Msrried 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Raca - American Indian, Blsck, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementsry/Secondary (0-12): 9TH GRADE
College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MOVER

16b. Kind of Business/Industry: MOVING COMPANY

17. Father's Name (First, Middle, Last): JOHNIE ISSAC JENKINS SR.

18. Mother's Name (First, Middle, Meiden Surname): ELIZA WOODS

19a. Informant's Name/Relationship (Type, Print): JOHNIE I. JENKINS SR. (FATHER)

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 424 TUXEDO ST. BALTIMORE, MD. 21211

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Placa of Disposition (Neme of cemetery, cremetory or other plece): KING MEMORIAL PARK

Date: 01-27-01

20c. Location - City or Town, State: WOODLAWN, MARYLAND

21. Signature of Funeral Service Licensee: Donald D. Brown

22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thst caused the death. Do not enter the mode of dying, such as cardiac or respirstory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): s. Gunshot Wound to the Neck

Due to (or ss s consequenca of):

Sequentially tist conditions, it sny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due to (or as s consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uss contribute to the causs of death? 1 [ ] Yss 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Wes en eutopsy performed? 1 [X] Yss 2 [ ] No

24b. Were sutopsy findings evallable prior to completion of cause ot desth? 1 [X] Yes 2 [ ] No

25. Wss case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one)
Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [X] Other (Specify) at scene

27. Manner of Death: 1 [ ] Nsturs l 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): Found: 01-21-2001

28b. Time of Injury: Found: 1:33 A M

28c. Injury st Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: Subject was shot

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify): Found: Street

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Found: 1400 Block Barnes Street, Baltimore, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, snd due to the cause(s) snd manner ss ststed. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinlon, death occurred at the time, date and placa, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: J. Pestaner, M.D.

29c. License number: O.C.M.E.

29d. Dete signed (Month, Day, Year): January 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year): JAN 25 2001

32. Registrar's Signature: Jenna G Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other trsumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020
Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM #17 per fh G791 012501 SS

Certificate of Death

Reg. No. 2001 01706

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES JONES, JR.

2. Data of Death Month Day Yaar: JANUARY 21,01

3. Tima of Death: 06:45 AM

4a Facility Nama (If not institution, giva street and number): 3806 DOLFIELD AVENUE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218 28 5540

6. Sax: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 68 Yrs.

If Undar 1 Yaar: Months / Days

If Undar 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Yaar): AUG.7,1932

9. Birthplace (Stata or Foreign Country): GEORGIA

Usual Rasidance of Decedant

10a. Stata: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Insida City Limits: 1 [X] Yas 2 [ ] No

10e. Street and Number: 3806 DOLFIELD AVENUE

10f. Zip Code: 21215

10g. Citizan of What Country?: U.S. OF A.

11. Marital Status: 1 [ ] Navar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1 [ ] Yas 2 [ ] No If Yas, Give Yaar or Datas: 1953-1955

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxicen, Puarto Rican, atc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, Whita, atc. Specify: BLACK

15. Decedant's Education (Specify only highast grada compliatad)

Elementary/Secondary (0-12): UNKNOWN

College (1-4or 5+): UNKNOWN

16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratirad): SECURITY GUARD

16b. Kind of Businass/Industry: SHOPPING CENTET

17. Fathar's Nama (First, Middla, Last): ~~CHARLESW JONES, SR.~~ Charles Jones, Sr.

18. Mothar's Name (First, Middla, Maidan Sumama): MARY BLACK

19a. Informant's Name/Ralationship (Type, Print): MARGARET JONES (WIFE)

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 3806 DOLFIELD AVE. BALTIMORE,MD. 21215

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar (Spacify)

20b. Place of Disposition (Name of cematary, crematory or othar place): GARRISON FOREST VET. CEM.

Data: 1/29/01

20c. Location - City or Town, Stata: OWINGS MILLS, MD.

21. Signatura of Funaral Sarvica Licansee: Lewis T. Gwynn

22. Nama and Addrass of Facility: LEWIS T. GWYNN FUNERAL HOME 21215-6393, 4517 PARK HEIGHTS AVE. BALTIMORE,MARYLAND

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused the daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only one cause on each line.

Approximata Interval Batwaan Onsat and Death

Immediata Causa (Final disaasa or condition rasulting in death)

a. myocardial infarction — Approximata Interval: hours

Dua to (or as a consaquanca of):

Saquantially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaasa or Injury that initiatad avants rasulting in daath) Last

b.

Dua to (or as a consaquanca of):

c.

Dua to (or as a consaquanca of):

d.

Part II. Othar significant conditions contributing to death but not rasulting in tha undarlying causa given in Part I.

Atrial fibrillation

ventricular arrhythmia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yas 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Wara autopsy findings availabla prior to complation of causa of daath? 1 [ ] Yas 2 [ ] No

25. Was casa rafarrad to medical examiner? 1 [ ] Yas 2 [X] No

26. Place of Daath (Check only one): Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA; Other: 4 [ ] Nursing Homa 5 [X] Rasidance 6 [ ] Othar (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding invastigation 6 [ ] Could not be datarmined

28a. Data of Injury (Month, Day Yaar)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Dascribe how injury occurred

28e. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify)

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifiar (Check only one): 1 [X] Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and placa, and due to tha cause(s) and manner as stated. 2 [ ] Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and dua to tha cause(s) and mannar statad.

29b. Signature and title of certifier: Robert M. Cooper MD

29c. License number: D30377

29d. Data signad (Month, Day, Yaar): 1/23/01

30. Nama and addrass of person who completed causa of daath (Itam 23a) (Type, Print): Robert M. Cooper MD 6503 PARK HEIGHTS AVE BALT MD 21215

State Registrar

31. Date filed (Month, Day, Yaar): JAN 25 2001

32. Ragistrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

2

4/x1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01707

Patient Known as Jones, Hannah

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hannah Jones

2. Date of Death: Month January Day 24 Year 2001

3. Time of Death: 12:35AM

4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: NA

Funeral Director

5. Social Security Number: 216-24-3174

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 2-4-1914

9. Birthplace (State or Foreign Country): Va

Usual Residence of Decedent

10e. State: Md

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5113 Woolverton Avenue

10f. Zip Code: 21215

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10th grade

College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic

16b. Kind of Business/Industry: Child Care Center

17. Father's Name (First, Middle, Last): Johnny Palmer

18. Mother's Name (First, Middle, Maiden Surname): Mary Taylor

19a. Informant's Name/Reletionship (Type, Print): Lionel A. Jones, Sr - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5113 Woolverton Ave Balto, Md 21215

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other piece): Druid Ridge Cem

Date: 1/27/01

20c. Location - City or Town, State: Balto, Md

21. Signature of Funeral Service Licensee: John B. Johnson Jr

22. Name and Address of Facility: Mark F. A. West 4300 Wabash Avenue Balto, Md 21215

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PANCREATIC CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

SEIZURES

HYPERTENSION

ASCITES

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Amy M Dvorcek, DO

29c. License number: RES 000

29d. Date signed (Month, Day, Year): JANUARY 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): AMY M. DVORCEK, DO SINAI HOSPITAL

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001 FEB 22 2001

32. Registrar's Signature: Jennifer B Sparks

DHMH 16 Rev 6/95

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Amende diten #7 per FHG791 1/25/2001 EW

Certificate of Death

Reg. No. 2001 01708

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Dete of Deeth Month	Day	Year	3. Time of Death
Bennie F. Johnson	01	22	01	7:00 p.m

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deeth	4c. County of Death
2124 Braddish Avenue	Baltimore	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthdey)	If Under 1 Yeer: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Deta of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
247-42-7743	1☐ M 2☒ F	90 ~~80~~ Yrs.			5-23-1910	S.C.

Usuel Residence of Decedant

10a. Stete	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	NA	Baltimore	1☒ Yes 2☐ No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
2124 Braddish Avenue	21216	U.S.A

11. Merital Stetus	12. Was Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Detes:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Businass/Industry
Elamantary/Secondary (0-12)	College (1-4or 5+)		
unk	unk	Cook	Convent

17. Father's Nema (First, Middla, Last)	18. Mothar's Neme (First, Middle, Maiden Sumame)
George Davis	Ella Jackson

19a. Informant's Neme/Ralationship (Type, Print)	19b. Mailing Addrass (Street and Number or Rurel Route Number, City or Town, State, Zip Code)
Peggy Ellison - Daughter	2124 Braddish Avenue Balto, Md 21216

20a. Method of Disposition	20b. Pleca of Disposition (Nama of cemetary, crematory or other pleca)	Date	20c. Location - City or Town, State
1☒ Buriel 2☐ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Othar (Specify)	Druid Ridge Cem	1/27/01	Baltimore, Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
John B. Johnson Jr	March F.A. West 4300 Wabash Avenue Balto, Md 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failura. List only one cause on each line.

Approximate Intarval Batween Onset and Death

Immedieta Cause (Final diseese or condition rasulting in death)
a. Hypertensive Cardiovascular disease

Dua to (or as a consequence of):
b. Congestive heart failure

Sequentially list conditions, if any, leading to immedieta cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest
Due to (or es a consequenca of):
c.

Due to (or es a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Wes case refarred to medical examiner?	26. Place of Death (Check only ona)	
1☐ Yes 2☒ No	Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete and placa, end due to the ceuse(s) and menner as stated.
2☐ **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, data end placa, and dua to the causa(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D39127	1/23/2001

30. Neme and addrass of person who completed cause of death (Item 23a) (Type, Print)
A. AHMED 821 N. Eutaw Street Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrer's Signeture
JAN 25 2001	Dennis D Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

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ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01709

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALBERT JEFFERSON

2. Date of Death Month: January Day: 16 Year: 2001

3. Time of Death: 115 pm

4a. Facility Name (If not institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-14-7106

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 28, 1920

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 35 N. Wheeler Ave.

10f. Zip Code: 21223

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - Americen Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 7th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bricklayer

16b. Kind of Business/Industry: Building

17. Father's Name (First, Middle, Last): Alexander Jefferson

18. Mother's Name (First, Middle, Maiden Surname): Bessie Brown

19a. Informant's Name/Relationship (Type, Print): Lauvenia M. Jefferson - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 35 N. Wheeler Ave. Balto, MD. 21223

20a. Method of Disposition: 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest V.A.

Date: 1-26-01

20c. Location - City or Town, State: Owings Mills, MD.

21. Signature of Funeral Service Licensee: Gary P. March

22. Name and Address of Facility: Gary P. March Funeral Home P.A. 270 Fredhilton Pass Balto, MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in death): Respiratory Failure

Due to (or as a consequence of):

b. Hypertension

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Pneumonia

Due to (or as a consequence of):

d. Sepsis

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Renal Failure, Encephalopathy, Multiple Decubitus Ulcers

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings eveilable prior to completion of ceuse of death? 1 ☐ Yes 2 ☑ No

25. Was cese referred to medicel examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: Govind MuKundan

29c. License number: P 14581

29d. Date signed (Month, Day, Year): 1/16/01

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print): Govind MuKundan, M.D. 90 Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001

32. Registrar's Signature: Barbara A Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RJD
ALVIN JONES
01-353-510

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01710

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALVIN HENRY JONES
2. Date of Death (Month, Day, Year): JANUARY 22, 2001
3. Time of Death: 0255 A.M.
4e. Facility Name (If not institution, give street and number): SIANI HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-17-8616
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 21 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 03-21-1979
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3014 Rosalind Ave.
10f. Zip Code: 21215
10g. Citizen of What Country: USA

11. Meritel Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): ALPHONSO H. JONES JR.
18. Mother's Name (First, Middle, Maiden Surname): BEVERLY JOHNSON

19a. Informant's Name/Reletionship (Type, Print): BEVERLY JONES, MOTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1201 BLACKFRIARS RD, BALTO. MD 21228

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removel from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Placa of Disposition (Name of cemetery, cremetory or other place): MOUNT ZION CEMETERY
Date: 1-26-01
20c. Location - City or Town, State: BALTIMORE

21. Signature of Funeral Service Licensee: ▶ Willie E. Howell Jr.
22. Name and Address of Facility: HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one causa on eech line. (Approximate Interval Between Onset end Death)

Immediate Cause (Finel disease or condition resulting in death): a. Gunshot Wound OF Head
Due to (or as a consequenca of):
Sequentially tist conditions, If any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lasf: b.
Due to (or as a consequence of):
c.
Due fo (or es e consequence of):
d.

Part tt. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): 1/22/01
28b. Time of Injury: 0200 (Found) M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Subject Shot
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Street (Found)
28f. Location (Street and Number or Rural Route Number, City or Town, State): Baltimore, Md.

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2 [X] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ J. Pestaner, M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): JANUARY 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended item#24a,25,27 perPHYG791 1/25/2001 EW

Certificate of Death

Reg. No. 2001 01711

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ernest Jones

2. Date of Death: Month 01 Day 07 Year 01

3. Time of Death: 11:38PM

4a. Facility Name (If not institution, give street and number): Univ MD Med Syst Hosp.

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 217-40-2812

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs./last birthday): 57 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov 25, 1943

9. Birthplace (State or Foreign Country): unk

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Jessup

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: P.O. Box 536

10f. Zip Code: 20794

10g. Citizen of What Country: USA

11. Marital Status: unk
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? unk
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.
Specify: black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): unk
College (1-4or 5+): unk

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk

16b. Kind of Business/Industry: unk

17. Father's Name (First, Middle, Last): unk

18. Mother's Name (First, Middle, Maiden Surname): unk

19a. Informant's Name/Relationship (Type, Print): UMMS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 22 S. Greene Street Baltimore, MD 21201

20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify): in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pancreatitis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HIV, Hepatitis C

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)
Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. License number: RE5000

29d. Date signed (Month, Day, Year): 01/07/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nelson TAYLOR Univ MD Hosp CCU, 22 S. Greene St.

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001

32. Registrar's Signature: Genevieve G Sparks

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01712

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOSEPH CALVIN AMOS JENKINS
2. Date of Death (Month, Day, Year): January 18, 2001
3. Time of Death: 4:15AM

4a. Facility Name *(If not institution, give street and number)*: 818 Hatherleigh Road
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-18-0846
6. Sex: 1☐M 2☐F — XX
7. Age *(In yrs. last birthday)*: 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 15, 1924
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐Yes 2☐No — XX
10e. Street and Number: 818 Hatherleigh Road
10f. Zip Code: 21212
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced — XX
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No — XX
If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1☐Yes 2☒No — XX Specify:
14. Race - American Indian, Black, White, etc.
Specify: White

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12):
College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Builder
16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: William Armour Jenkins
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Katherine Amos

19e. Interment's Name/Relationship *(Type, Print)*: Sally Brady Jenkins Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 818 Hatherleigh Road Baltimore, Maryland 21212

20a. Method of Disposition: 1☐Burial 2☐Cremation 3☐Removal from State 4☒Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Howard University
Date: 1/18/01
20c. Location - City or Town, State: Washington D.C.

21. Signature of Funeral Service Licensee: Dennis Stephen Kenaka
22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode ot dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. coronary artery disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: colon cancer

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death *(Check only one)*
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Laurence H Ross MD
29c. License number: D0035727
29d. Date signed *(Month, Day, Year)*: 1/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 1205 York Rd Suite 22 Lutherville, MD 21093

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01713

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ralph John Kirchner, Sr.

2. Date of Death Month / Day / Year: January 22 2001

3. Time of Death: 9:15 PM

4a. Facility Name *(If not institution, give street and number)*: Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-12-8167

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 78 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 5 1922

9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedant

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 34 Belhaven Dr.

10f. Zip Code: 21236

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): +2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Electrical Contractor

16b. Kind of Business/Industry: Commercial

17. Father's Name *(First, Middle, Last)*: George Kirchner

18. Mother's Name *(First, Middle, Maiden Surname)*: Queen Smith

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Rosalie Kirchner/ Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 34 Belhaven Dr. Baltimore, Md. 21236

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Dulaney Valley Memorial Gardens

Date: 1-26-01

20c. Location - City or Town, State: Timonium, Md.

21. Signature of Funeral Service Licensee: K. J. Young

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Emphysema

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kenneth McDowell MD

29c. License number: RD 203331

29d. Date signed *(Month, Day, Year)*: January 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR Kenneth McDowell 9000 Franklin Square Drive Baltimore, MD 21237

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001

32. Registrar's Signature: Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Kirchner Ralph

5+1

01-0372-003
jhm
WILLARD K KIMBALL

AMEND #28a per ME G793 030701 SS
AMEND ITEM: #2 PER PHY G792 2-28-01 WR.
AMENDED ITEMS# 23a,b,c,pt II,27,& 28a-f per ME G792 021601 SS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01714

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLARD KENNY KIMBLE, JR.

2. Date of Death Month Day Year: ~~JANUARY 22, 2001~~ 1-20-01

3. Time of Death: 02:05 AM

4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 235-80-8226

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 49 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 4, 1951

9. Birthplace (State or Foreign Country): WEST VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 7502 OLD STAGE ROAD

10f. Zip Code: 21061

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1971-73

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SUPERVISOR

16b. Kind of Business/Industry: PRODUCE

17. Father's Name (First, Middle, Last): WILLARD K. KIMBLE, SR.

18. Mother's Name (First, Middle, Maiden Surname): ELWANDA McDONALD

19a. Informant's Name/Relationship (Type, Print): MARY ELLEN KIMBLE (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7502 OLD STAGE ROAD, GLEN BURNIE, MD. 21061

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetary, cremetory or other place): CEDAR HILL CEMETERY

Date: JAN. 26, 2001

20c. Location - City or Town, State: BROOKLYN PARK, MD

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name end Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. HEMOPERITONEUM

Due to (or as a consequence of):
b. PERITONEAL DIALYSIS TREATMENT

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. CHRONIC RENAL INSUFFICIENCY

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.: ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings availeble prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Rasidanca 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be datarmined

28e. Date of Injury (Month, Day Year): ~~1-18-01~~ 1/19/01

28b. Time of Injury: unknown M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: attempt to place peritoneal dialysis catheter

28a. Place of Injury - At home, farm, straat, factory, offica building, etc. (Specify): hospital

28f. Location (Straat end Number or Rural Route Number, City or Town, State): 3001 S. Hanover St., Balto, MD

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to tha cause(s) and mannar es stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at tha time, date and place, and dua to the cause(s) and manner stated.

29b. Signature and title of certifiar: ▶ Dennis J. Chuteau

29c. License number: OCME

29d. Date signed (Month, Day, Year): JANUARY 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chuteau 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001

32. Registrar's Signature: ▶ [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01715

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Howard Laughlin Roy
2. Date of Death (Month, Day, Year): January 17 2001
3. Time of Death: 8:43 AM
4a. Facility Name (If not institution, give street and number): 3347 S. Leisure World Blvd
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 475-16-0670
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 6, 1908
9. Birthplace (State or Foreign Country): Minnesota

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3347 S. Leisure World Blvd
10f. Zip Code: 20906
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): +5
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): teacher
16b. Kind of Business/Industry: physchologist

17. Father's Name (First, Middle, Last): Joseph Roy
18. Mother's Name (First, Middle, Maiden Surname): Ida Irish

19a. Interment's Name/Relationship (Type, Print): Ethel Roy/spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3347 S. Leisure World Blvd Silver Spring, MD 20906

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place)
Date
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): e. Arteriosclerotic Cardiovascular Disease — Approximate Interval Between Onset and Death: years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Benjamin Hamilton MD
29c. License number: D08381
29d. Date signed (Month, Day, Year): January 17, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): BENJAMIN HAMILTON, MD 1811 Prince Philip Drive, Rng, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 01716

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Edmund Ledvinka

2. Date of Death: Month January Day 24 Year 2001

3. Time of Death: 8 AM

4a. Facility Name (If not institution, give street and number): 298 Montrose Avenue

4b. City, Town, or Location of Death: Essex

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-50-0666

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 55 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10-14-1945

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Freeland

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 19843 Goremill Road

10f. Zip Code: 21053

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Edmund F. Ledvinka, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Catherine Hildebrandt

19a. Informant's Name/Relationship (Type, Print): Edmund Ledvinka Jr./Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19843 Goremill Road Freeland, MD 21053

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Pieca ol Disposition (Name of cemetery, crematory or other place): Holy Redeemer Cemetery

Date: 1-27-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas L. Cvach

22. Name and Address of Facility: Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Baltimore MD 21237

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode ol dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardio-Pulmonary Failure

Due to (or as e consequence of):

b. Arteriosclerotic Cardio Vascular Disease

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings availeble prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Sisters House

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date ol Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Charles F. O'Donnell

29c. License number: D-09383

29d. Date signed (Month, Day, Year): January 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles F. O'Donnell/MD 1 Hamlet Hill Rd Baltimore MD 21218

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001

32. Registrer's Signature: Bonnie B Sparks

FEB 2 0 2001

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01717

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Leonard Joseph Layman
2. Date of Death Month / Day / Year: January 12, 2001
3. Time of Death: 2:50PM
4a. Facility Name *(If not institution, give street and number)*: VA MARYLAND HEALTH CARE SYSTEM
4b. City, Town, or Location of Death: FORT HOWARD
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-05-3469
6. Sex: 1☐ M 2☐ F — X
7. Age *(In yrs. last birthday)*: 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: July 24, 1916
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Insida City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3 Eastship Road
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Yaer or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*
14. Race - Amarican Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 Years — College (1-4or 5+):
16a. Decedent's Usuet Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Typewriter Technician
16b. Kind of Business/Industry: Royal Typewriter

17. Father's Name *(First, Middle, Last)*: John Lewandowski
18. Mother's Name *(First, Middle, Maiden Sumeme)*: Josephine Melecki

19a. Informant's Neme/Retationship *(Type, Print)*: Mr. Robert Layman (Son)
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 1 Eastship Road Dundalk, Maryland 21222

20a. Method of Disposition: 1☒ Buriet 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cametery, cremetory or other piece)*: Most Holy Redeemer Cem.
Date: 1/16/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Nama and Addrass of Fecility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complications that caused the daeth. Do not antar tha mode of dying, such es cardiec or respiratory arrest, shock, or heert faiture. List only one cause on eech line.

Approximata Interval Between Onset and Death

Immediate Cause (Finet disaase or condition resulting in death): a. Cancer, lung with metastasis — 2 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in deeth) Lest:
b.
Due to (or as e consequence of):
c.
Dua to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uee contribute to the cauee of death? 1☒ Yee 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior to completion of cause ot deeth? 1☐ Yes 2☐ No

25. Was case referred to medicat exeminar? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, tactory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyetcian:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner steted.

29b. Signeture and title of certifier: Aurora C. Tan, M.D.
29c. License number: D14958
29d. Date signed *(Month, Dey, Year)*: 01-12-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR AURORA C.TAN, M.D. 9600 noth Point Road, Fort Howard M.D. 212052

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 25 2001
32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Layman, Leonard
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01718

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bernard Joseph LaSalle
2. Date of Death (Month, Day, Year): January 15, 2001
3. Time of Death: 1321
4a. Facility Name (If not institution, give street and number): 6200 Westchester Park Drive
4b. City, Town, or Location of Death: College Park
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 310-36-4383
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): unk.
9. Birthplace (State or Foreign Country): Canada

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: College Park
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 6200 Westchester Park Drive
10f. Zip Code: 20740
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 6
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Veterinarian
16b. Kind of Business/Industry: USDA Veterinary Biologics

17. Father's Name (First, Middle, Last): unk.
18. Mother's Name (First, Middle, Maiden Surname): unk.

19a. Informant's Name/Relationship (Type, Print): Joseph A. Reafferty/ Personal Rep.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4701 Sangamore Road Bethesda, MD 20816

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory, Inc.
Date: 1/26/01
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Laura C. Hardesty
22. Name and Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Drive Baltimore, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
e. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Salvador Sylvester DO
29c. License number: H00559 27
29d. Date signed (Month, Day, Year): January 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Salvador Sylvester, 3001 Hospital Drive, Cheverly, Maryland 20785

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

8

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 01719

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ERNESTINE LEONA LECATOR

2. Date of Death Month / Day / Year: JAN. 24, 2001

3. Time of Death: 8:10AM

4a. Facility Name *(If not institution, give street and number)*: GILCHRIST HOSPICE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-42-9913

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 54 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: FEB. 6, 1946

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1733 MORELAND AVENUE

10f. Zip Code: 21216

10g. Citizen of What Country?: USA.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 YRS; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SCHOOL TEACHER

16b. Kind of Business/Industry: BALTO CITY PUBLIC SCHOOLS

17. Father's Name *(First, Middle, Last)*: ROY McCOY

18. Mother's Name *(First, Middle, Maiden Surname)*: REGINA FIELDS

19a. Informant's Name/Relationship *(Type, Print)*: TRACY DORSEY (DAUGHTER)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1733 MORELAND AVE., BALTIMORE, MD. 21216

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ARBUTUS CEMETERY

Date: 01-27-01

20c. Location - City or Town, State: ARBUTUS, MARYLAND

21. Signature of Funeral Service Licensee: Ruth N. Miller

22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTO. MD. 21217

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

1-24-01 0810

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Ovarian Cancer — year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☒ Other *(Specify)* HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Lecator, Ernestine

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D0051926

29d. Date signed *(Month, Day, Year)*: 1/24/01

30. Name and address of person who completed cause of death (item 23a) (Type, Print): Helen Gordon MD 6565 N. Charles St, Baltimore MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01720

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward Walter Lipka
2. Date of Death (Month, Day, Year): January 20, 2001
3. Time of Death: 4:30 PM
4a. Facility Name (If not institution, give street and number): Union Memorial Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 216-28-5572
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10/16/1930
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Middle River
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 10016 Crane Lane
10f. Zip Code: 21220
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: Korean conflict
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accountant
16b. Kind of Business/Industry: Steel Mill

17. Father's Name (First, Middle, Last): Stanley Lipka
18. Mother's Name (First, Middle, Maiden Surname): Julia Biskup

19a. Informant's Name/Relationship (Type, Print): Audrey B. Lipka (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10016 Crane Lane, Baltimore, Maryland 21220

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem. Gar.
Date: 1/24/2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Pneumonia	one day
Due to (or as a consequence of): b.	Cardiogenic shock	3 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Coronary artery disease	10 years
Due to (or as a consequence of): d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Diabetes

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: 05695
29d. Date signed (Month, Day, Year): 1/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] Svescher MD Union Memorial Hospital

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature: Barbara D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2001 JAN 24 PM 10: 10

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 01721

Physician /Medical Examiner

1. Decedent's Nama *(First, Middle, Last)*: JEROME LUNTZ
2. Data of Death Month Day Year: JANUARY 23, 2001
3. Tima of Death: 4:20 AM
4a Facility Name *(If not institution, giva street and number)*: RUXTON OF PIKESVILLE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218-07-5163
6. Sex: X 1 M 2 F
7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: SEP. 14, 1915
9. Birthplace *(Stata or Foraign Country)*: MD

Usual Residence of Decedent

10a. Stata: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 Yas 2 X No
10e. Street and Number: 4125 RONIS ROAD
10f. Zip Code: 21208
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 Never Married 2 X Married 3 Widowed 4 Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1 Yes 2 X No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CLOTHING CUTTER
16b. Kind of Business/Industry: MEN'S CLOTHING

17. Father's Name *(First, Middle, Last)*: BENJAMIN LUNTZ
18. Mother's Name *(First, Middle, Maiden Surname)*: SARAH GOLDSTEIN

19a. Informant's Name/Relationship *(Type, Print)*: SHELDON LUNTZ / SON
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3916 CARTHAGE ROAD - RANDALLSTOWN, MD 21133

20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: SHAAREI ZION CONGREGATION
Date: 1/24/01
20c. Location - City or Town, State: ROSEDALE, MD

21. Signature of Funeral Service Licensee: ▶ Scott M. Cutler
22. Nama and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complications thet ceused the death. Do not entar tha mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Acute MI
Due to (or as a consequence of):
b. Diabetes Mellitus
Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last
Dua to (or as a consequence of):
c. Congestive Heart Failure
Dua to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
Diabetic Neuropathy
PEG for feeding

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was cese referred to medical examiner? 1 Yes 2 X No

26. Place of Death *(Check only one)*: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA — Other: 4 X Nursing Home 5 Residance 6 Othar *(Specify)*

27. Manner of Death: 1 X Natural 2 Accident 3 Suicida 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 Yas 2 No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Deborah Morin MD
29c. License number: D31364
29d. Data signed *(Month, Day, Year)*: 1/23/01

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): 21 Crossroads Dr. #250 Owings Mills MD 21117

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001
32. Registrar's Signature: ▶ Brenda G Sparks

ORIGINAL

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-0346-510
CJ
Walter Mahaven

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01722

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WALTER MAHAVEN
2. Date of Death: Month: January; Day: 21; Year: 2001
3. Time of Death: 11:04 A.M.
4a. Facility Name (If not institution, give street and number): Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 185-16-6106
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 15, 1923
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1931 E. Pratt Street
10f. Zip Code: 21231
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): engineer
16b. Kind of Business/Industry: government

17. Father's Name (First, Middle, Last): Frank Mahaven
18. Mother's Name (First, Middle, Maiden Surname): Anna Mahaven

19a. Informant's Name/Relationship (Type, Print): Lana P. Kopas/spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1931 E. Pratt Street Baltimore, MD 21231

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigetion, In my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): January 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. LAON Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature: Jennie D Sparks

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ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01723

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: David Sidney Meeks
2. Date of Death Month / Day / Year: Jan. 23 2001
3. Time of Death: 1:25 AM
4a. Facility Name *(If not institution, give street and number)*: 106 Greenbrier Rd.
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 228-23-1873
6. Sex: 1☐M 2☐F — X
7. Age *(In yrs. last birthday)*: 35 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 16 1965
9. Birthplace *(State or Foreign Country)*: CA

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 106 Greenbrier Rd.
10f. Zip Code: 21286
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT usa retired)*: Youth Minister
16b. Kind of Business/Industry: Ministry - Young Life

17. Father's Nama *(First, Middle, Last)*: William Meeks
18. Mother's Name *(First, Middle, Maiden Surname)*: Jacqueline Pember

19a. Informant's Name/Retationship *(Type, Print)*: Tracey R. Meeks/wife
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 106 Greenbrier Rd., Towson, MD 21286

20a. Mathod of Disposition: 1☒Burial 2☐Cremation 3☐Ramoval from Stata 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Dulaney Valley Memorial Gardens — Date: 1/26/01
20c. Location - City or Town, State: Timonium, MD 21093

21. Signature of Funeral Service Licensee: Lowell M. Lemmon
22. Nama and Address of Facility: Lemmon Funeral Home, 10 W. Padonia Rd., Timonium, MD 21093

Physician /Medical Examiner

23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ANAPLASTIC ASTROCYTOMA — 4 YEARS

Due to (or as a consequence of):

Sequentially list conditions, If any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uas contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☒Residenca 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Dete of tnjury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Ptace of tnjury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and piece, and due to the cause(s) and menner es stated. 2☐**Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stuart Grossman MD
29c. Licensa number: 023683
29d. Data signed *(Month, Day, Year)*: 1/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stuart Grossman, M.D. CRB Bldg., 1650 Orleans St., G93, Balto., MD 21231

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001
32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

To Be Completed by Funeral Director

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #31 PER D.V.R. G791 1-25-01 WR.
AMENDED ITEMS#23a,ptII,27,28a-f per ME G808 062502 ss

Certificate of Death

Reg. No. 2001 01724

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FREDERICK A MCGOWAN

2. Date of Death: Month JANUARY Day 20 Year 2001

3. Time of Death: 9:45 PM

4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death: RANDALSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 416 60 3831

6. Sex: 1☐M 2☐F XX

7. Age (In yrs. last birthday): 54 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 15, 1946

9. Birthplace (State or Foreign Country): Alabama

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Pikesville

10d. Inside City Limits: 1☐Yes XX☐No

10e. Street and Number: 7433 Rockridge Road

10f. Zip Code: 21208

10g. Citizen of What Country?: USA

11. Marital Status: XX1☐Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐Yes 2XX☐No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Photographer

16b. Kind of Business/Industry: Self-Employeed

17. Father's Name (First, Middle, Last): Fred Elber McGowan

18. Mother's Name (First, Middle, Maiden Surname): Nancy Moon

19a. Informant's Name/Relationship (Type, Print): David Wamsley Guardian

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): eMerge Inc. 9180 Rumsy Road Columbia, Maryland 21045

20a. Method of Disposition: 1☐Burial XX☒Cremetion 3☐Removel from Stete 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Balto.-Washington Cr. Date: 1/25/01

20c. Location - City or Town, State: Laurel, Maryland

21. Signeture of Funeral Service Licensee: Tracy H Carpenter

22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ANOXIC ENCEPHALOPATHY

Due to (or as e consequence of):

b. DUE TO CHOKING ON FOOD BOLUS

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2XX Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year): 1-9-2002

28b. Time of Injury: 5:30p M

28c. Injury at Work? 1☐Yes 2☒No

28d. Describe how injury occurred: Subject choked on food

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify): Other: Group Home Residence

28f. Location (Street and Number or Rural Route Number, City or Town, State): 7433 Rockridge Road Woodlawn, Maryland

29a. Certifier (Check only one): 1☑Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: ▶ amlamud, MD

29c. License number: D0055798

29d. Date signed (Month, Day, Year): 01/20/2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): ARIEL MALAMUD NORTHWEST HOSPITAL CENTER

State Registrar

31. Date filed (Month, Day, Year): 01/20/2001

32. Registrar's Signature: JAN 25 2001 Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-0323-510
mnmr
Yorkston Miller

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS# 23 & 27 per ME G792 022101 SS

Certificate of Death

Reg. No. 2001 01725

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Yorkston Miller

2. Date of Death Month: January Day: 19, Year: 2001

3. Time of Death: 2018 pm

4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 119-54-5528

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 57 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 6-20-1943

9. Birthplace (State or Foreign Country): Jamaica W.I.

Usual Residence of Decedent

10a. State: Md

10b. County: Baltimore

10c. City, Town or Location: Randallstown

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4300 Holbrook Road

10f. Zip Code: 21133

10g. Citizen of What Country?: U S A

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+): 2 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mill Wright

16b. Kind of Business/Industry: General Motors

17. Father's Name (First, Middle, Last): Charles Miller

18. Mother's Name (First, Middle, Maiden Surname): Daisey McKensey

19a. Informant's Name/Relationship (Type, Print): Alice Miller- Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4300 Holbrook Avenue Randallstown, Md 21133

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Druid Ridge Cemtery

Data: 1-25-01

20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeral Service Licensee: John B. Johnson

22. Name and Address of Facility: March F/H West 4300 Wabash Avenue Baltimore, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. HYPERTENSIVE CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residance 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore M. Kenyon

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): January 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. Kenyon 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001

32. Registrar's Signature: Geneva G Sparks

ORIGINAL

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 01726

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
CHARLES IRA MUMAW	January 23, 2001	1:10 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Hospice of Baltimore, Gilchrist Center	Baltimore	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-09-0395	1☒ M 2☐ F	94 Yrs.					Dec. 7, 1906	Md.

Usual Residence of Decedent

10a. Stete	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Baltimore	Parkville	1☐ Yes 2☒ No

10e. Street end Number	10f. Zip Code	10g. Citizen of What Country?
8820 Walther Blvd. Apt. 2304	21234	USA

11. Meritel Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Bleck, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Detes:	1☐ Yes 2☒ No *Specify:*	*Specify:* White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
8		Superintendent	Glenn L. Martin

17. Father's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Sumeme)
Charles Ira Mumaw	Annie Greta Spellman

19e. Informent's Neme/Reletionship (Type, Print)	19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Mary E. McGeady/daughter	6 Old Boxwood Lane Lutherville, Md. 21093

20e. Method of Disposition	20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)	Most Holy Redeemer	1/26/01	Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Neme end Address of Fecility
Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert feilure. List only one ceuse on eech line.

		Approximate Interval Between Onset end Deeth
Immediate Cause (Finel diseese or condition resulting in deeth)	e. CAD	years
Sequentiellγ tist conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest	b. Due to (or es a consequence of):	
	c. Due to (or es a consequenca of):	
	d.	

Pert ff. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an eutopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical exeminer?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) hosp. to

27. Menner of Deeth	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and pleca, end due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier	29c. License number	29d. Dete signed (Month, Dey, Year)
MD	D0051926	1/24/01

30. Nems and address of person who completed cause of deeth (Item 23a) (Type, Print)
Helen Gordon MD 6565 N. Charles St, Baltimore MD 21204

State Registrar

31. Dete filed (Month, Dey, Year)	32. Registrar's Signeture
JAN 25 2001	

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Charles Mumaw Jan 23, 2001 1:10 AM

10

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01727

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph A. Moser
2. Data of Death — Month: Jan. Day: 23, Year: 2001
3. Time of Death: 6:05 A.M.
4a. Facility Name (If not institution, give street and number): Manor Care Towson
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-01-5089
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4/28/1918
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 8140 Glen Gary Road
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 2 years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Tool & Die Maker
16b. Kind of Business/Industry: Western Electric

17. Father's Name (First, Middle, Last): Charles A. Moser
18. Mother's Name (First, Middle, Maiden Surname): Mary Heim

19e. Informant's Name/Relationship (Type, Print): Neva D. Moser Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8140 Glen Gary Road Baltimore, MD 21234

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Moreland Memorial Park
Date: 1/26/01
20c. Location - City or Town, State: Hillendale, MD

21. Signature of Funeral Service Licensee
22. Name and Address of Facility: The Johnson Funeral Home, P.A. 8521 Loch Raven Blvd. Towson, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Dementia	> 2 years
Due to (or as a consequence of): b.	h/o C.V.A	> 2 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D42736
29d. Date signed (Month, Day, Year): 1-23-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): AYMAN AKKAD, M.D., 7600 OSLER DRIVE, S-411, TOWSON, MD 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item 18 per FH,G791,01/25/01dhb

Certificate of Death

Reg. No: 2001 01728

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death (Month, Day, Year)	3. Time of Death
EDWARD	JACOB	MOSS	JAN 20 2001	9AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
LORIEN NURSING HOME	MT. AIRY	CARROLL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
185-09-3233	1☒ M 2☐ F	103 Yrs.			NOV 17 1897	PHILADELPIA,PA.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
FL	BROWARD	POMPANO BEACH	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1114 WEST CYPRESS DRIVE	33069	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		SALES PERSON	RUG

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
LEON MOSKOWITZ	ZLOTA ~~ABRAMOWITZ~~ ABROMOWITZ

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
REBECCA BARMACK/DAUGHTER	1114 WEST CYPRESS DRIVE POMPANO BEACH, FL.33069

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)	MONTEFIORE CEMETERY	1/22/01	JENKINTOWN,PA.

21. Signature of Funeral Service Licensee: ▶ Scott M. Cuttler

22. Name and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert feilure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute myocardial infarction	5min
	Due to (or as a consequence of):	
Sequentially list conditions, if eny, leading to Immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and menner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ R Robert S Hughes	DO 5111	1/20/01

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)
Robert S. Hughes,MD, Lorien Nursing Home

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 25 2001	▶ Barbara G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 01729

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last): Bernard Marshall

2. Date of Death: Month: January Day: 23 Year: 2001

3. Time of Death: 11:05 PM

4a. Facility Name (If not institution, give street and number): Northwest Hospital Center

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore

5. Social Security Number: 197-05-0289

6. Sex: 1☐ M 2☐ F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 22, 1909

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Reisterstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11709 Reisterstown Rd.

10f. Zip Code: 21136

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc.
Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 10
College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager

16b. Kind of Business/Industry: Bendix Field Engineering

17. Father's Name (First, Middle, Last): William Marshall

18. Mother's Name (First, Middle, Maiden Surname): Mary Marshall

19a. Informant's Name/Relationship (Type, Print): James Marshall - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20205 S.W. Farmington Rd. Aloha, Oregon 97007

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Evergreen Mem. Gardens

Date: Jan. 27, 2001

20c. Location - City or Town, State: Finksburg, Md.

21. Signature of Funeral Service Licensee: J. Garth Eckhardt

22. Name and Address of Facility: Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, Md. 21117

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Christopher Davis MD

29c. License number: D55609

29d. Date signed (Month, Day, Year): January 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Christopher Davis 2401 West Belvedere Avenue Baltimore Maryland 21215

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001

32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

01-0355-005

B.K.S

ANITA NAFTEL

AMEND ITEMS: #23 PART I, 27 PER MEO G791 1-30-01 WR.

AMEND ITEM: #8 PER F.H. G791 1-25-01 WR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01730

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
ANITA	NAFTEL	JAN. 22, 2001	0016 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NORTHWEST HOSPITAL CENTER	RANDALLSTOWN	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-54-2795	1☐ M 2☒ F	58 Yrs.					OCT 15 1942	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	OWINGS MILLS	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
35 TAHOE CIRCLE	21117	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		NONE	NONE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JACK BENNETT NAFTEL	LILLIAN ROSENSTEIN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ESTHER FRIBUSH/AUNT	3211 CLARKS LANE #421 BALTIMORE, MD.21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	HEBREW YOUNG MEN	1/24/01	WOODLAWN, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	O.C.M.E	JAN. 22, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J. CLIFTON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 25 2001	Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-0358-510
crn
Elma Oglesby

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#20b-c perFHG791 1/29/01 EW

Certificate of Death

Reg. No. 2001 01731

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELMA ELAINE OGLESBY
2. Data of Death — Month: January Day: 22 Year: 2001
3. Time of Death: 10:50 A.M.
4a. Facility Name (If not institution, give street and number): 604 Roundview Road
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 229-26-5007
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB. 15, 1925
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 604 ROUNDVIEW ROAD
10f. Zip Code: 21225
10g. Citizen of What Country?: USA.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE. College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SECRETARY
16b. Kind of Business/Industry: BALTO. PUBLIC SCHOOL SYS.

17. Father's Name (First, Middle, Last): JAMES L. PRESCOTT
18. Mother's Name (First, Middle, Maiden Surname): ALMA BANKS

19a. Informant's Name/Relationship (Type, Print): SONDRA BROOKER (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 438 W. WOODLAWN ST., PHILADELPHIA PA. 19144

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, cramatory or other place): ~~KING MEMORIAL PARK~~ Arbutus Cemetery
Date: 01-27-01
20c. Location - City or Town, State: ~~WOODLAWN, MARYLAND~~ ARBUTUS

21. Signature of Funeral Service Licensee: John Williams
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No
24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) at scene

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore M. King MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): January 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature: Jeanne B Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01732

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NAOMI S. OWINGS
2. Date of Death (Month, Day, Year): JANUARY 21,01
3. Time of Death: 6:10PM
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-20-1354
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 29 1926
9. Birthplace (State or Foreign Country): WASHINGTON, DC.

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 106 CLAREDON AVENUE
10f. Zip Code: 21208
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BOOKKEEPER
16b. Kind of Business/Industry: FOOD

17. Father's Name (First, Middle, Last): MAX OBSTLER
18. Mother's Name (First, Middle, Maiden Surname): ROSE WHITE

19a. Informant's Name/Relationship (Type, Print): EUGENE OWINGS/HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 106 CLAREDON AVENUE BALTIMORE, MD. 21208

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): B'NAI ISRAEL CONGREGATION
Date: 1/23/01
20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: Jay Alan Levinson
22. Name and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC BLADDER CANCER
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: DIABETES

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: K. S. RAO. M.D.
29c. License number: D43462
29d. Date signed (Month, Day, Year): JANUARY 21,01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K. S. RAO. M.D. NORTHWEST HOSPITAL CENTER RANDALLSTOWN, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature: S Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01733

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALMEDA MAY OTTO

2. Date of Death (Month, Day, Year): JANUARY 23 2001

3. Time of Death: 8:55AM

4a. Facility Name (If not institution, give street and number): HOLLY HILL NURSING HOME

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-07-0104

6. Sex: 1☐ M 2☒ F (XX)

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 2, 1912

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No (XX)

10e. Street and Number: 6 Murdock Road

10f. Zip Code: 21212

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married (XX) Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No (XX) If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No (XX) Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cleric

16b. Kind of Business/Industry: Printing

17. Father's Name (First, Middle, Last): Robert Holland Blatchley

18. Mother's Name (First, Middle, Maiden Surname): Susan Barnett

19a. Informant's Name/Relationship (Type, Print): Richard E Otto SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6 Murdock Road Baltimore, Maryland 21212

20a. Method of Disposition: 1☒ Burial (XX) 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery

Date: 1/26/01

20c. Location - City or Town, State: Parkville, Maryland

21. Signature of Funeral Service Licensee: Dennis Stephen Kenakos

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Bronchopneumonia — 2 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D-17041

29d. Data signed (Month, Day, Year): 24 JANUARY 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARC I. LEAVEY MD 1205 YORK ROAD STE 38 LUTHERVILLE MD 21093

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01734

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hilda M. Parker

2. Date of Death: Month 1 / Day 22 / Year 01

3. Time of Death: 505 P

4a. Facility Name (If not institution, give street and number): The Wesley Home 2211 W. Rogers Ave,

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-20-7086

6. Sex: 1☐ M 2☒ F (X)

7. Age (In yrs. last birthday): 96 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July29,1904

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes (X) 2☐ No

10e. Street and Number: 2211 W. Rogers Avenue

10f. Zip Code: 21209

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed (XX) 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No (XXX) If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No (XX) Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): William Beam

18. Mother's Name (First, Middle, Maiden Surname): Mary Teal

19a. Informant's Name/Relationship (Type, Print): Helen Barnes (Friend)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13696 Lexington Dr. Mt. Airy, MD 21771

20a. Method of Disposition: 1☒ Burial (XX) 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cemetery

Date: 1/25/01

20c. Location - City or Town, State: Pikesville, MD

21. Signature of Funeral Service Licensee: Jerry H Carpenter

22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, MD 21211

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary artery Disease

Due to (or as a consequence of):

c. Advanced age.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Squamus cell Cancer of mouth Metastatic

Diabetes, asthma

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown (X)

24a. Was an autopsy performed? 1☐ Yes 2☒ No (X)

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No (X)

25. Was case referred to medical examiner? 1☐ Yes 2☒ No (X)

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home (X) 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural (X) 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (X) 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R. Fields, MD.

29c. License number: D21464

29d. Date signed (Month, Day, Year): 1/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT LIBERTO, MD. 3508 BANK ST 21224

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001

32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Parker. Hilda

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01735

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Patrick J. Pugh
2. Date of Death (Month, Day, Year): Jan. 23, 2001
3. Time of Death: 8:35 P.M.
4a. Facility Name *(If not institution, give street and number)*: Stella Maris Hospice
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-32-2666
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 64 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 6/2/1936
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Joppa
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 24 Neptune Drive
10f. Zip Code: 21085
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 8 Years
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher
16b. Kind of Business/Industry: Baltimore County School System

17. Father's Name *(First, Middle, Last)*: William Pugh
18. Mother's Name *(First, Middle, Maiden Surname)*: Edna Price

19a. Informant's Name/Relationship *(Type, Print)*: Joan E. Pugh Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 24 Neptune Drive Joppa, MD 21085

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory, Inc. — Date: 1/25/01
20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funeral Service Licensee: M. Neal Coleman
22. Name and Address of Facility: The Johnson Funeral Home, P.A. 8521 Loch Raven Blvd. Towson, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Renal Cell Cancer
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* Hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D43725
29d. Date signed *(Month, Day, Year)*: January 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001
32. Registrar's Signature: Peter B Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

January 23, 2001 8:35 p.m.
Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Patrick J. Pugh
Division of Vital Records, P.O. Box 68760,

01-0381-510
crn
Latonia Sanquenette Pressley

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01736

AMENDED ITEMS# 1,23a,27,28a-f,per M.E. G792 020201 SS

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~LATONIA SANQUENETTE PRESLEY~~ Latonia Sanquenette Pressley
2. Date of Death (Month, Day, Year): January 21, 2001
3. Time of Death: 3:25 A.M.
4a. Facility Name (If not institution, give street and number): Lorien Frankford Nursing Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-86-4972
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 33 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 27, 1967
9. Birthplace (State or Foreign Country): Ga.

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1711 E. 31st Street
10f. Zip Code: 21218
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Clerical
17. Father's Name (First, Middle, Last): John Henry Pressley, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Jeanette Mims
19a. Informant's Name/Relationship (Type, Print): Jeanette M. Pressley/mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1711 E. 31st Street Baltimore, Md. 21218
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Memorial
Date: 1/25/01
20c. Location - City or Town, State: Timonium, Md.
21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. COMPLICATIONS OF HEAD INJURIES

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year): 5/23/99
28b. Time of Injury: 6:17a M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: subject was a passenger in a taxi cab which was struck by a vehicle which ran a red light while being pursued by
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): street
28f. Location (Street and Number or Rural Route Number, City or Town, State): 1500 E. Coldspring Ln Baltimore, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): January 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mary G. Fiffe M.D. 111 Penn Street, Baltimore, Maryland 21201

2

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

ADH
GOMTI R. PATEL
01-0325-005
Amended Item#26 perPHYG791 1/25/2001 EW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01737

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gomti R. Patel
2. Date of Death: Month JANUARY Day 19 Year 2001
3. Time of Death: 1441 PM
4a. Facility Name (If not institution, give street and number): 3108 WALLFORD DRIVE Apt. A
4b. City, Town, or Location of Death: DUNDALK
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 145-86-7728
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 44 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 1, 1956
9. Birthplace (State or Foreign Country): India

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3108 Wallford Drive Apt. A
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Indian

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): Unknown
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home maker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Mathuvlal H. Patel
18. Mother's Name (First, Middle, Maiden Surname): Sitaben Mathuvlal Patel

19a. Informant's Name/Relationship (Type, Print): Rasik Patel/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3108 Wallford Drive Apt. A Dundalk, Maryland 21222

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp.
Date: Jan.22,2001
20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: ▶ Stephanie Massey
22. Name and Address of Facility: The Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Baltimore, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Blunt Force Injuries of Head and Strangulation
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) AT SCENE

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☒ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): Found 1/19/01
28b. Time of Injury: 1430HR
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Subject struck & strangled
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 3108 A Wallford Drive Dundalk Maryland

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Theodore M. King MD
29c. License number: OCME
29d. Date signed (Month, Day, Year): JANUARY 20, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature: ▶ Geneva G Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01738

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Francis W. Pramschufer, Jr.

2. Date of Death (Month, Day, Year): Jan. 24, 2001

3. Time of Death: 5:10 a.m.

4a. Facility Name (If not institution, give street and number): 3704 Southern Avenue

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-12-1808

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 9, 1918

9. Birthplace (State or Foreign Country): Baltimore, Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 3704 Southern Avenue

10f. Zip Code: 21214

10g. Citizen of What Country? United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No. If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: Baltimore City Schools

17. Father's Name (First, Middle, Last): Francis W. Pramschufer Sr.

18. Mother's Name (First, Middle, Maiden Surname): Anna Ford

19a. Informant's Name/Relationship (Type, Print): Mary E. Pramschufer (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3704 Southern Avenue Baltimore, Md. 21214

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp. Date: 1/25/01

20c. Location - City or Town, State: Towson Maryland

21. Signature of Funeral Service Licensee: Milton J Knight Jr ▶ Milton J. Knight Jr.

22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 9 months

Immediate Cause (Final disease or condition resulting in death): a. Lung carcinoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ David J. Clark MD

29c. License number: D0052583

29d. Date signed (Month, Day, Year): January 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 5601 Loch Raven Blvd. Baltimore, MD 21239

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001

32. Registrar's Signature: ▶ Penny G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01739

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Huston PEGRAM
2. Date of Death (Month, Day, Year): JANUARY 20, 2001
3. Time of Death: 10:19 AM
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 118-14-5670
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 75 Yrs. | Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APRIL 24, 1925
9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 3801 CANTERBURY RD.
10f. Zip Code: 21218
10g. Citizen of What Country?: USA.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE | College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): STATION ENGINEER
16b. Kind of Business/Industry: DEPT. OF HOUSING

17. Father's Name (First, Middle, Last): JOSEPH PEGRAM
18. Mother's Name (First, Middle, Maiden Surname): CHRISTINE CRAWFORD

19a. Informant's Name/Relationship (Type, Print): GLORIA PEGRAM (WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3801 CANTERBURY RD., BALTO. MD. 21218

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST | Date: 01-25-01
20c. Location - City or Town, State: OWINGS MILLS, MD.

21. Signature of Funeral Service Licensee: Joseph A. Brown
22. Name and Address of Facility: JOSEPH A. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD. 21217

Physician ~~Medical~~ Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA — ONE WEEK

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ron Elfenbein, MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): January 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ron Elfenbein Johns Hopkins Hospital 600 N. Wolfe Street Baltimore MD

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01740

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LEVI ABRAM PILSON
2. Date of Death (Month, Day, Year): January 21, 2001
3. Time of Death: 3:10 AM
4a. Facility Name *(If not institution, give street and number)*: MANOR CARE-RUXTON
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore County

Funeral Director

5. Social Security Number: 229-12-8476
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug 26, 1914
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore County
10c. City, Town or Location: Towson
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7001 North Charles Street
10f. Zip Code: 21204
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): ; College (1-4or 5+): 2 yrs
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Machinist
16b. Kind of Business/Industry: Aerospace

17. Father's Name *(First, Middle, Last)*: George A. Pilson
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Jane Turner

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Dove D. Cresswell (Sister)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5444 Princess Drive, Baltimore, Maryland 21237

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chestnut Grove Ch. Cem.
Date: 1/24/01
20c. Location - City or Town, State: Phoenix, Maryland

21. Signature of Funeral Service Licensee: Martin D. Lawson
22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only one* cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Massive Cerebro-vascular accident	6 days
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hypertension	yrs
Due to (or as e consequence of):		
	c. Atrial fibrillation	7 days
Due to (or as e consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetic Mellitus type II

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D-17992
29d. Date signed *(Month, Day, Year)*: January 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Khin M. Tun, 1312 Goucher Blvd., Towson, Maryland 21286

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01741

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CATHERINE BEATRICE RUSSELL

2. Date of Death (Month, Day, Year): January 21, 2001

3. Time of Death: 4:26 PM

4a. Facility Name *(If not institution, give street and number)*: Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-18-5059

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 79 Yrs.

If Under 1 Yaer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept 8, 1921

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 11 N. Hawthorne Road

10f. Zip Code: 21220

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: dietary account clerk

18b. Kind of Business/Industry: medical

17. Father's Name *(First, Middle, Last)*: James Edward Hughes

18. Mother's Name *(First, Middle, Maiden Surname)*: Marie C. Daniels

19a. Informant's Name/Ralationship *(Type, Print)*: Mary Monteith/daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 101 N. Charter Rad #L Glen Burnie, MD 21061

20a. Method of Disposition: 1☐ Burial 2☐ Cramation 3☐ Ramoval from State 4☒ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or other place)*:

Data:

20c. Location - City or Town, Stata:

21. Signeture of Funeral Service Licensee: Ronald S. Wade, Director

22. Nama and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not anter the moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on aach lina.

Approximate Interval Between Onset and Death

Immediate Causa (Final disease or condition resulting in death)

a. HYPOXEMIA — 36 HOURS

Due to (or as a consequence of):

b. Pulmonary Edema

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Myocardial Infarction

Due to (or as a consequence of):

d. Metastatic Lymphoma - Non Hodgkins

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Ischemic Heart Disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*:

28b. Time of Injury:

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred:

28e. Placa of Injury - At homa, farm, street, factory, offica building, etc. *(Specify)*:

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*:

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at tha time, date and place, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, daath occurred et the time, date and place, and dua to the cause(s) and manner stated.

29b. Signetura and Title of certifiar:

29c. License number: H54913

29d. Date signed *(Month, Day, Year)*: 01/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Prosper Sanchez 9000 Franklin Square Drive Baltimore, Md 21237

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001

32. Registrar's Signeture: Jennie B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Russell Catherine
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01742

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alex E. Rudick
2. Date of Death (Month, Day, Year): January 24, 2001
3. Time of Death: 9:05 AM
4a. Facility Name (If not institution, give street and number): Manor Care
4b. City, Town, or Location of Death: Chevy Chase
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 125-05-6471
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 6, 1913
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8700 Jones Mill Road
10f. Zip Code: 20815
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Business
16b. Kind of Business/Industry: Self-Employed

17. Father's Name (First, Middle, Last): Harry Rudick
18. Mother's Name (First, Middle, Maiden Surname): Ida Gorelick

19a. Informant's Name/Reletionship (Type, Print): Ian Rudick/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 798 Verdun Clarksburg, WV 26301

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.
Date: 1-25-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregor
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Left Hydropneumothorox

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Pneumonia

Due to (or as a consequence of):

c. Dementia/Alzheimer's Disease

Due to (or as a consequence of):

d. Hypothyroidism

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Paraplegia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Vohra M.D
29c. License number: D-20274
29d. Date signed (Month, Day, Year): January 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): D. Vohra, M.D. 7710 Bradley Blvd. Bethesda, MD 20817

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CPS
01-0314-031
MICHAEL ROBERTSON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01743

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Michael Robertson
2. Date of Death (Month, Day, Year): January 19, 2001
3. Time of Death: 9:08 AM
4a. Facility Name (If not institution, give street and number): 10515 LORAIN AVE.
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-66-9349
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 54 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 23,1946
9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10515 Lorain Avenue
10f. Zip Code: 20901
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): Francis Robertson
18. Mother's Name (First, Middle, Maiden Surname): Julia Scrivener

19a. Informant's Name/Relationship (Type, Print): John Walsh/ Cousin
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1509 Castle Cliff Place Silver Spring, MD 20904

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory, Inc.
Date: 1/25/01
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Laura C. Hardesty
22. Name and Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Drive Baltimore, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Cardiovascular

~~Due to (or as a consequence of):~~
b. Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? Limited 1☑ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) SCENE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J Pestaner MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): JANUARY 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature: Jeanne B Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01744

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary C. Rahnis

2. Date of Death (Month, Day, Year): JANUARY 24 2001

3. Time of Death: 9:07 A.M.

4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death: ROSEDALE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-03-4252

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 11, 1918

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1643 Cape May Road

10f. Zip Code: 21221

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Book Keeper

16b. Kind of Business/Industry: Construction Company

17. Father's Name (First, Middle, Last): Richard H. Sibley

18. Mother's Name (First, Middle, Maiden Surname): Rita Colley

19a. Informant's Name/Relationship (Type, Print): Rita Adams - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1635 Cape May Road, Essex, Maryland 21221

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Gardens of Faith Mem.Cem. Date: Jan. 27, 2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Ave., Essex, Maryland 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ASPIRATION PNEUMONIA

Due to (or as a consequence of):
b. CEREBRAL VASCULAR ACCIDENT

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
DEMENTIA, PERIPHERAL NEUROPATHY

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Babak Imanoel MD

29c. License number: H53939

29d. Date signed (Month, Day, Year): 1/24/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BABAK IMANOEL, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

RAHNIS, MARY
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 01745

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nancy Marie Rehmeyer

2. Date of Death — Month: January Day: 23 Year: 2001

3. Time of Death: 3:15 a.m.

4a. Facility Name (If not institution, give street and number): Stella Maris Hospice at Mercy

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 218-70-8389

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 41 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth (Month, Day, Year): 1/18/1960

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1000 East Joppa Road

10f. Zip Code: 21286

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): n/a

16b. Kind of Business/Industry: n/a

17. Father's Name (First, Middle, Last): Ernest Dorsey Rehmeyer

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Wrenn Hasson

19a. Informant's Name/Relationship (Type, Print): Ernest Dorsey Rehmeyer (father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 511-L Cider Press Ct., Joppa, Maryland 21085

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem. Gardens

Date: 1/26/2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: Bruzdzinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Breast CARCINOMA — 2 years

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Stella Maris at Mercy
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marvin J. Feldman MD

29c. License number: D07930

29d. Date signed (Month, Day, Year): January 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marvin J. Feldman MD 301 ST PAUL PLACE Baltimore, Md 21202

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001

32. Registrar's Signature: Jeanne G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

3

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01746

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY RONDO
2. Date of Death: Month 1 Day 23 Year 2001
3. Time of Death: 10 AM
4a. Facility Name (If not institution, give street and number): 6840 Leslie Road
4b. City, Town, or Location of Death: Chase
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-22-3198
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 11, 1924
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Chase
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6840 Leslie Road
10f. Zip Code: 21220
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Anthony Bognanni
18. Mother's Name (First, Middle, Maiden Surname): Catherine Bagli

19a. Informant's Name/Relationship (Type, Print): Charles J. Rondo/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6840 Leslie Road Chase Maryland 21220

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Redeemer Cemetery
Date: 1/27/01
20c. Location - City or Town, State: Baltimore

21. Signature of Funeral Service Licensee: Thomas J. Weber Jr.
22. Name and Address of Facility: David J. Weber Funeral Homes, P.A. 401 S. Chester Street Baltimore, Maryland 21231

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CARCINOMATOSIS	2 months
Due to (or as a consequence of):	b. Metastatic Carcinoma of LUNGS	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ANEMIA, DEPRESSION,

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Gauhar MD
29c. License number: D 18326
29d. Date signed (Month, Day, Year): 1/23/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NAEEM GAUHAR, Essex Med. Ctr, Baltimore MD, 21221

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: Sandra G Sparks

FEB 2 5 2001

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

RKD

01-0218-510

FRANK STEWART

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01747

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Frank Randolph Stewart

2. Date of Death Month / Day / Year: JANUARY 13, 2001

3. Time of Death: 5:10P.M.

4a. Facility Name *(If not institution, give street and number)*: 2200 HOMEWOOD AVE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-38-0105

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 60 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 07-02-1940

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10a. Street and Number: 2200 Homewood Ave.

10f. Zip Code: 21218

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 th — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Funeral Assistant

18b. Kind of Business/Industry: Mortuary

17. Father's Name *(First, Middle, Last)*: Frank R. Stewart

18. Mother's Name *(First, Middle, Maiden Surname)*: Hilda Smith

19a. Informant's Name/Relationship *(Type, Print)*: Claudia T. Turner (Niece)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 222 E. 25 th Street Balto., Md. 21218

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Voshells Memorial Park

Date: 1/26/00

20c. Location - City or Town, State: Balto., Md. 21202

21. Signature of Funeral Service Licensee: Dennis B. Caple

22. Name and Address of Facility: Dennis B. Caple Funeral Home 4601 York Rd. Balto., Md. 21212

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, If any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated evants resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Dua to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? INSPECTION 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☒ Other *(Specify)* SCENE

27. Menner of Death: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Phyeician**: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end manner as stated. 2 ☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: M.D.

29c. License number: O.C.M.E.

29d. Date signed *(Month, Day, Year)*: JANUARY 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY G. RIPPLE M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 25 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 017418

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HARRY SCOTT

2. Date of Death — Month: JANUARY Day: 20 Year: 2001

3. Time of Death: 03:35

4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW MEDICAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 218-46-8646

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 53 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth (Month, Day, Year): June 14, 1947

9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 6209 Shipview Way

10f. Zip Code: 21224

10g. Citizen of What Country?: Usa

11. Maritel Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 7 yrs.

College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Cook

16b. Kind of Business/Industry: Bar

17. Father's Neme (First, Middle, Last): Harry Eugene Scott II

18. Mother's Name (First, Middle, Maiden Surneme): Mary Priscilla Klein

19a. Informant's Name/Relationship (Type, Print): Patricia Scott wife

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 6209 Shipview Way, Baltimore, Md. 21224

20e. Method of Disposition: 1 [ ] Buriel 2 [X] Cremetion 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Bayview Crematory

Dete: Jan 22 2001

20c. Location - City or Town, Stete: Baltimore City, Md.

21. Signature of Funeral Service Licensee: Anthony C. Connelly

22. Neme end Address of Facility: Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one ceuse on each line.

Approximete Interval Between Onset and Deeth

Immediete Ceuse (Finel disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION — 36 HRS

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ACUTE RENAL FAILURE

MESENTERIC ISCHEMIA

ASPIRATION PNEUMONIA

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [X] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred et the time, date end piece, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: MD

29c. License number: RES-000

29d. Date signed (Month, Day, Year): JANUARY 20, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): AUDREY LIU 4940 EASTERN AVE BALTIMORE MD 21224

State Registrar

31. Dete filed (Month, Dey, Year): JAN 25 2001

32. Registrer's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01749

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas Spatafore
2. Date of Death: Month 1 Day 24 Year 01
3. Time of Death: 1:15 PM
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 193-01-2642
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 11, 1916
9. Birthplace (State or Foreign Country): Pa.

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10a. Street and Number: 7047 Dunbar Rd
10f. Zip Code: 21222
10g. Citizen of What Country?: USA

11. Meritel Stetus: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yas, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 9 yrs. | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Steamfitter
16b. Kind of Business/Industry: Steel

17. Father's Name (First, Middle, Last): John Spatafore
18. Mother's Neme (First, Middle, Maiden Surname): Carma Creta

19a. Informant's Neme/Reletionship (Type, Print): Vivian Spatafore wife
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 7047 Dunbar Rd, Dundalk, Md. 21222

20a. Method of Disposition: 1 ☒ Burlel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Oaklawn Cemetery | Dete: Jan 27, 2001
20c. Location - City or Town, Stata: Dundalk, Md.

21. Signature of Funerel Service Licensee: ▶ Anthony C. Connelly
22. Neme and Address of Fecility: Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart feilure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
Immediete Cause (Finel disease or condition resulting in deeth) a.	Ventricular fibrillation	Minutes
Due to (or es e consequence of):		
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in deeth) Lest b.	myocardial infarction	minutes
Due to (or es e consequence of):		
c.	Coronary artery disease	years
Due to (or es e consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Ventricular fibrillation arrest on 1/8/01

Myocardial infarction 1/8/01

End stage renal disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Wes an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Piece of Deeth (Check only one): Hospitel: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA | Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Menner of Death: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: ▶ Michael Harper MD
29c. License number: D43732
29d. Date signed (Month, Day, Year): January 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Harper, MD 5505 Hopkins Bayview Circle, Baltimore, MD 21224

State Registrar

31. Dete filed (Month, Day, Year): JAN 25 2001
32. Registrer's Signature: ▶ G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01750

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RHODIA SHIELDS
2. Date of Death (Month, Day, Year): 01-21-2001
3. Time of Death: 11:03PM
4a. Facility Name (If not institution, give street and number): FUTURECARE-EASTPOINT REHAB & NURSING CTR.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-24-3288
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT. 12 1914
9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: ☒ Yes 2☐ No
10e. Street and Number: 505 BRIDGEVIEW RD.
10f. Zip Code: 21225
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DOMESTIC
16b. Kind of Business/Industry: HOME

17. Father's Name (First, Middle, Last): CLAUD MOSELY
18. Mother's Name (First, Middle, Maiden Surname): MARY LONG

19e. Informant's Name/Reletionship (Type, Print): HENRY CODGELL/SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2114 CAMERON DR., BALTO., MD. 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CEDAR HILL CEMETERY
Date: 1/26/2001
20c. Location - City or Town, Stete: BALTO., MD.

21. Signature of Funeral Service Licensee: James A. Morton
22. Name and Address of Facility: JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST. BALTO., MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CEREBROVASCULAR ACCIDENT
Due to (or as a consequence of): b. CONGESTIVE HEART FAILURE
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): c. MALNUTRITION
Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Satinder K Tuteja M.D.
29c. License number: D27188
29d. Date signed (Month, Day, Year): 1/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Satinder K Tuteja 2 Market Place Baltimore MD 21202

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01751

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HOWARD STUMP

2. Date of Death Month: JANUARY Day: 23, Year: 2001

3. Time of Death: 0805 HRS.

4a. Facility Name *(If not institution, give street and number)*: GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-12-7153

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb.17,1926

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 902 Beaumont Avenue

10f. Zip Code: 21212

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yaar or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexicen, Puarto Rican, atc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indian, Black, Whita, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 / College (1-4or 5+)

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Inspector

16b. Kind of Business/Industry: public Department of works

17. Father's Name *(First, Middle, Last)*: John M. Stump

18. Mother's Name *(First, Middle, Maiden Surname)*: Catherine E. Calp

19a. Informant's Name/Relationship *(Type, Print)*: Margaret Stump/ Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 902 Beaumont Avenue Baltimore, MD 21212

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory, Inc.

Date: 1/24/01

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funaral Service Licensee: ▶ [signature]

22. Name and Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Drive Baltimore, MD 21286

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not antar tha moda of dying, auch as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SEPSIS — 3 DAYS

Due to (or as a consequence of):

Sequentiellly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last:

b. LARGE CELL LYMPHOMA — UNKNOWN

Dua to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: CORONARY ARTERY DISEASE

23b. Did tobacco use contributs to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☒ No

25. Was casa referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the ceuse(s) and mannar stated.

29b. Signature and title of certifier: ▶ Kofi A. Appiah, Resident Physician

29c. License number: P13450

29d. Date signed *(Month, Day, Year)*: JANUARY 23, 2001

30. Nama and address of person who completed ceuse of daath (Item 23a) (Type, Print): KOFI A. APPIAH, GOOD SAMARITAN HOSPITAL, BALTIMORE, MD.

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 25 2001

32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

$5

8+1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01752

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LOUIS STEINBERG

2. Date of Death (Month, Day, Year): JANUARY 22 2001

3. Time of Death: 11 05 AM

4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-01-2730

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): FEB. 24, 1917

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☐ Yes 2 X No

10e. Street and Number: 725 MT. WILSON LANE

10f. Zip Code: 21208

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No — If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.): 1 ☐ Yes 2 XX No — Specify:

14. Race - American Indian, Black, White, etc. — Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 5+ College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CERTIFIED PUBLIC ACCOUNTANT

16b. Kind of Business/Industry: INTERNAL REVENUE SER.

17. Father's Name (First, Middle, Last): SAM STEINBERG

18. Mother's Name (First, Middle, Meiden Surneme): IDA BASKIN

19a. Informant's Name/Relationship (Type, Print): LARRY STEINBERG / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12123 LONG LAKE DRIVE - OWINGS MILLS, MD 21117

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other place): BETH EL MEMORIAL PARK

Date: 1/24/01

20c. Location - City or Town, State: RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee: [signature]

22. Nama and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA — 6 DAYS

Due to (or as a consequenca of):

Sequentially list conditions, If any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initieted events rasulting in death) Last

b. Due to (or as a consequenca of):

c. Due to (or as a consequenca of):

d.

Part II. Other signifficant conditions contributing to deeth but not resulting in the underlying cause given in Part I.: DEMENTIA

23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Was case referred to medical examinar? 1 ☐ Yes 2 X No

26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Othar: 4 ☐ Nursing Home 5 ☐ Residenca 8 ☐ Other (Specify)

27. Manner of Death: 1 X Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury: M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: C. Ravi MD

29c. Licensa number: D37333

29d. Date signed (Month, Day, Year): JANUARY 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C. RAVI MD, NHC, BALTIMORE, MD 21133

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001

32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01753

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: NETTIE MAE SCOTT
2. Date of Death Month Day Year: JANUARY 23, 2001
3. Time of Death: 6:35am
4a. Facility Name *(If not institution, give street and number)*: G.B.M.C.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-36-2787
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 78 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JANUARY 21, 1913
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: n/a
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3141 JEFFERY RD.
10f. Zip Code: 21244
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* AFRO AMERICAN

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10TH — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: COOK
16b. Kind of Business/Industry: PRIVATE FAMILY

17. Father's Name *(First, Middle, Last)*: WILLIE CHESTNUT
18. Mother's Name *(First, Middle, Maiden Surname)*: JULIE

19a. Informant's Name/Relationship *(Type, Print)*: GEORGE W. CHESTNUT(SON)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3141 JEFFERY RD. BALTO. MD. 21244

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: EB COUNTLINE #1 CHURCH CEM. — Date: JAN. 29, 2001
20c. Location - City or Town, State: SELMA, ALABAMA
21. Signature of Funeral Service Licensee: Calvin B. Scruggs
22. Name and Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME 1412E. PRESTON ST. BALTO. MD. 21213

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Resperatory Faulure	4 hours
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Coronary artery Disease	5 Years
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Att. Attending Physician
29c. License number: D53642
29d. Date signed *(Month, Day, Year)*: Jan. 23 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KAO2004 3007 E Northern Parkway Baltimore MD 21214

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001
32. Registrar's Signature:

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

ORIGINAL

JAN 2 3 2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01754

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rachel Spicer
2. Date of Death (Month, Day, Year): January 22 2001
3. Time of Death: 11:55 pm
4a. Facility Name (If not institution, give street and number): University of Maryland
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218 07 6258
6. Sex: 1☐ M 2☑ F
7. Age (If yrs. last birthday): 83 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APR 1, 1917
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 2414 E. Jefferson St.
10f. Zip Code: 21205
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): JANITRESS
16b. Kind of Business/Industry: Annapolis School System

17. Father's Name (First, Middle, Last): Thomas Surgeon
18. Mother's Name (First, Middle, Maiden Surname): Rachel Linum

19a. Informant's Name/Relationship (Type, Print): Joseph Spicer
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2414 E. Jefferson St. Balto. Md 21205

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): John Wesley-Annapolis Memorial Cem. Date: 1/27/2001
20c. Location - City or Town, State: Annapolis, Md.

21. Signature of Funeral Service Licensee: ▶ Glenn Adam James
22. Name and Address of Facility: Marshall W. Jones, Jr. F-H. PA 4101 Edmondson Ave. Balto. MD 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Respiratory failure
Due to (or as a consequence of):
b. bilateral pleural effusions
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Ana E Maldonado, MD
29c. License number: 31068O
29d. Date signed (Month, Day, Year): January 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ana E Maldonado 22 S. Green St. Balt, Md 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01755

AMEND#8 PER F.H. G792 2-12-2001 JAB

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANNA MINDERLEIN STREB

2. Date of Death Month Day Year: January 23, 2001

3. Time of Death: 8:15 PM

4a. Facility Name (If not institution, give street and number): College Manor, Inc.

4b. City, Town, or Location of Death: Lutherville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-30-3399

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): ~~Nov. 13, 1905~~ 11-16-05

9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Glen Arm

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 26 Gunpowder Rd.

10f. Zip Code: 21057

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assistant to the Director

16b. Kind of Business/Industry: Hopkins Medical Arts

17. Father's Name (First, Middle, Last): Conrad Minderlein

18. Mother's Name (First, Middle, Maiden Surname): Veronica Ulsch

19a. Informant's Name/Relationship (Type, Print): Mr. Alan J. Streb/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 26 Gunpowder Rd. Glen Arm, Md. 21057

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. John the Evangelist

Date: 1/27/01

20c. Location - City or Town, State: Hydes, Md.

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)
a. Aspiration Pneumonitis — 1 wk.

Due to (or as a consequence of):
b. Stroke

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as e consequence of):
c.

Due to (or es a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William D. McConnell MD

29c. License number: D42129

29d. Date signed (Month, Day, Year): 1-24-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William D. McConnell 500 W. University Baltimore

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001

32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Anna M. Streb Jan. 23, 2001 8:15 PM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01756

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Sandrock

2. Date of Death: Month 01 Day 22 Year 2001

3. Time of Death: 6:00 pm

4a. Facility Name (If not institution, give street and number): Hospice Of Baltimore Gilchrist Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 045-14-2277

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11-24-1922

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 302 Brook Road

10f. Zip Code: 21286

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Registered Nurse

16b. Kind of Business/Industry: Baltimore County Schools

17. Father's Name (First, Middle, Last): Gerald McDonough

18. Mother's Name (First, Middle, Maiden Surname): Anna Mitchell

19a. Informant's Name/Relationship (Type, Print): Mr. Paul W. Sandrock (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 302 Brook Road, Towson, Maryland 21286

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp.

Date: 1-24-01

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: ▶ Wallace S. Brooks, Jr.

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary Arrest

Due to (or as a consequence of):

b. Chronic Obstructive Pulmonary Disease — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Malnutrition; Pelvic Abscess from Ruptured Diverticulitis (11/2000)

Hypercalcemia secondary to Primary Hyperparathyroidism

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☑ Other (Specify) Inpatient Hospice

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Raymond W. Wilson MD

29c. License number: D41476

29d. Date signed (Month, Day, Year): 01.22.2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Raymond W. Wilson M.D., 6565 N. Charles St. #416, Baltimore, Maryland 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001

32. Registrar's Signature: ▶ Deanna G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 29d per Dr.,G791,01/25/01dhb

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01757

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM THOMAS ULSCH, SR.

2. Data of Death (Month, Day, Year): January 19, 2001

3. Time of Death: 12:20 AM

4a. Facility Name (If not institution, give street and number): Stella Maris

4b. City, Town, or Location of Death: Timonium

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-03-1570

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): June 24, 1917

9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedant

10a. State: Md.

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 902 Martell Ct. Unit K

10f. Zip Coda: 21014

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☒ Yas 2☐ No. If Yas, Giva Year or Dalas: WW-II

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No Specify:

14. Race - Amaricen Indian, Black, Whita, atc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed): Elementary/Secondary (0-12): 12; Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Plumbing Inspector

16b. Kind of Business/Industry: Baltimore County

17. Fathar's Nama (First, Middle, Last): Thomas Ludwig Ulsch

18. Mothar's Nama (First, Middle, Maidan Surname): Mary Metzger

19a. Informant's Name/Ralationship (Type, Print): Mrs. Dorothy R. Ulsch/wife

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda): 902 Martell Ct. Unit K Bel Air, Md. 21014

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Name of cematary, crametory or other place): Garrison Forest Vetrans

Data: 1/23/01

20c. Location - City or Town, Stata: Owings Mills, Md.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Addrass of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part1. Enlar tha disaasa, or complications that caused tha death. Do not anlar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaen Onset and Death

Immadiata Causa (Final disaasa or condition resulting in daath): a. Acute myocardial infarction — MINS

Dua to (or as a consequence of): Arteriosclerosis — YEARS

Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Diseasa or injury that initiated evants resulting in death) Last:

b. Dua to (or as a consequance of):

c. Dua to (or as a consequance of):

d.

Part II. Other significant conditions contributing to death but not resulting in tha underlying ceusa givan in Part I. Arteriosclerosis, Hypertension, Stroke.

23b. Did tobacco use contribute to the cauee of death? 1☐ Yee 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of ceuse of death? 1☐ Yas 2☐ No

25. Was cesa rafarred to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death (Check only ona): Hospital: 1☐ Inpaliant 2☐ ER/Outpaliant 3☐ DOA; Other: 4☒ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifiar (Check only one): 1☒ Certifying Physician: To tha best of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha ceusa(s) and mannar stated.

29b. Signatura and title of certifiar: [signature] MD

29c. License number: 15504

29d. Data signed (Month, Day, Year): 01/19/01

30. Nama and addrass of parson who completed ceusa of daath (Item 23a) (Type, Print): Dr. Nakhuda - Stella Maris - 2300 Dulaney Valley Rd., Timonium, Md. 21093

State Registrar

31. Data filed (Month, Day, Year): JAN 25 2001

32. Registrar's Signatura: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ULSCH, WILLIAM

6+1

RKD

01-0350-510

ROBERTA VAUGHN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01758

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROBERTA VAUGHN

2. Date of Death — Month: JANUARY; Day: 21; Year: 2001

3. Time of Death: 9:27P.M.

4a. Facility Name *(If not institution, give street and number)*: 3947 PENHURST AVE

4b. City, Town, or Location of Death: ~~BALTIMORE~~

4c. County of Death:

Funeral Director

5. Social Security Number: 214-68-4870

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 43 Yrs.

If Under 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: 7-13-57

9. Birthplace *(State or Foreign Country)*: BALTO. MD

Usual Residence of Decedent

10a. State: MD.

10b. County:

10c. City, Town or Location: BALTO.

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3947 Penhurst Ave

10f. Zip Code: 21215

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Educetion *(Specify only highest grada completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: NURSE

16b. Kind of Business/Industry: PRIVATE

17. Father's Name *(First, Middle, Last)*: EDWARD VAUGH

18. Mother's Neme *(First, Middle, Maiden Surneme)*: FLORENCE BRYANT

19a. Informant's Name/Relationship *(Type, Print)*: THERESA SIMMONS

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1109 N. Woodington Rd. BALTO. MD. 21229

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or other piece)*: BAYVIEW CREMATORY Dete: 1-25-01

20c. Location - City or Town, State: BALTO. MD.

21. Signature of Funeral Service Licensee: Wesley Chavis

22. Name and Address of Facility: 2007 EASTERN AVE CHAVIS F. H. BALTO. MD. 21231

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in deeth)

a. COCAINE AND ALCOHOL INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiete ceuse. Entar Undarlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause givan in Part I.

23b. Did tobacco use contribute to the causa of death? 1☐ Yas 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medicel examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* SCENE

27. Manner of Deeth: 1☐ Natural 2☐ Accident 3☐ Suicida 4☐ Homlcide 5☐ Pending invastigetion 6☒ Could not be determined

28a. Date of Injury *(Month, Day Year)*: FOUND: 1-21-01

28b. Time of Injury: UNKNOWN M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: HOME

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 3947 PENHURST AVE. BALTIMORE, MD

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piace, and due to the cause(s) and manner stated.

29b. Signatera and title of certifier:

29c. Licansa number: O.C.M.E.

29d. Data signed *(Month, Day, Year)*: JANUARY 22, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: # 20A-C 21,22 PER F.H. G791 1-30-01 WR. *Certificate of Death* Reg. No. 2001 01759

DONALD WILT.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DONALD E. WILT

2. Date of Death Month Day Year: JANUARY 18 2001

3. Time of Death: 04:50 PM

4a Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 283-26-5939

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 70 Yrs. If Under 1 Yaar: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 16, 1930

9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3618 S. Hanover Street

10f. Zip Code: 21225

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowad 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yaar or Datas: '47-50

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 11 College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): truck driver

16b. Kind of Business/Industry: newspaper

17. Father's Name (First, Middle, Last): unk

18. Mother's Name (First, Middle, Maiden Surname): unk

19a. Informant's Name/Relationship (Type, Print): Douglas Fox/stepson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6036 Bellegrove Rd Baltimore, MD 21225

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY INC. Date: 1-29-01

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: DAWN F. MCDONALD Ronald S. Wade, Director

22. Name and Address of Facility: CREMATORY SOCIETY OF MD, INC. State Anatomy Board 635 W. Baltimore Street 299 FREDERICK RD. BALTIMORE, MD 21228 ~~Baltimore, MD 21201~~

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only *one* causa *on* each line.

Approximate Interval Between Onset and Daath

Immediate Cause (Final disease or condition resulting in death)
a. MALIGNANT PLEURAL EFFUSSION — 2 WEEKS

Due to (or as a consequence of):
b. NON SMALL CELL CARCINOMA OF LUNG — 1 YEAR

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

HYPERTENSION

EMPHYSEMA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jaswinder M-D

29c. License number: RES 000

29d. Date signed (Month, Day, Year): JANUARY 18 2001

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): JASWINDER S KHOSLA, 3001 SOUTH HANOVER STREET, BALTIMORE, 21225

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01760

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY WITHERSPOON
2. Date of Death: Month JAN. Day 19 Year 2001
3. Time of Death: 5:00 AM
4a. Facility Name (If not institution, give street and number): 801 WINTERS LANE, APT. # 105
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 577-32-7628
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 17, 1927
9. Birthplace (State or Foreign Country): SOUTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 801 WINTERS LANE, APT # 105
10f. Zip Code: 21228
10g. Citizen of What Country?: USA.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): UNKNOWN
18. Mother's Name (First, Middle, Maiden Surname): ALMETA CLARK

19a. Informent's Name/Relationship (Type, Print): EULA WITHERSPOON (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3713 OAK AVENUE, BALTIMORE, MD. 21207

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): WOODLAWN CEMETERY
Date: 01-24-01
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTO, MD. 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Cardiac arrythemia — 1 HR
Due to (or as a consequence of):
b. Atherosclerotic heart disease — 5 HRS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Congestive heart failure — 1 yr
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic renal failure. peripheral arterial disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D30494
29d. Date signed (Month, Day, Year): 1/23/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K DESAI MD 4660 Willows Ave Baltimore MD 21229

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

01-0331-510

ARLIE WHITZ

ASP AMEND ITEM: #23 PART I, 27, 28A-F PER MEO G791 1-30-01 WR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01761

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): Arlie Whitt					2. Date of Death Month: JANUARY Day: 20 Year: 2001			3. Time of Death: 11:40 A
4a. Facility Name (If not Institution, give street and number): 165 N. CURLEY ST.				4b. City, Town, or Location of Death: BALTIMORE			4c. County of Death: N/A	
5. Social Security Number: 212-86-4291	6. Sex: 1☒ M 2☐ F	7. Age (In yrs. last birthday): 38 Yrs.	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year): SEPT 22, 1962		9. Birthplace (State or Foreign Country): Kentucky	
Usual Residence of Decedent								
10a. State: Maryland	10b. County: N/A	10c. City, Town or Location: 165 N. Curley Street					10d. Inside City Limits: 1☒ Yes 2☐ No	
10e. Street and Number: 165 N. Curley Street		10f. Zip Code: 21224			10g. Citizen of What Country? USA			
11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:			14. Reca - American Indian, Black, White, etc. Specify: White			
15. Decedent'a Eduoetion (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machine Operator			16b. Kind of Business/Industry: Printing Company			
17. Father's Name (First, Middle, Last): Arlie Whitt					18. Mother's Neme (First, Middle, Maiden Surname): Ruth Pennington			
19e. Informent's Neme/Reletionship (Type, Pnht): Mary Hoxter/Sister		19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 241 Baltimore Avenue Baltimore, MD 21222						
20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	20b. Place of Disposition (Name of cemetery, cremetory or other piece): Metro Crematory Inc.	Date: 1-23-01	20c. Location - City or Town, State: Baltimore, MD					
21. Signature of Funerel Service Licensee: Edward A. Gregorchik		22. Name and Address of Feoility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228						

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or complioations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. NARCOTIC AND COCAINE INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performed? 1☒ Yes 2☐ No

24b. Ware autopsy findings available prior to completion of ceuse of death? 1☒ Yes 2☐ No

25. Wes case referred to medicel examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) SCENE

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined

28a. Date of Injury (Month, Dey Year): Found: 1-20,2001

28b. Time of Injury: FOUND: 10:30 A M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: UNKNOWN

28e. Place of Injury - At home, farm, atreet, fectory, office building, etc. (Specify): RESIDENCE

28f. Location (Street end Number or Rural Route Number, City or Town, Stete): 165 N. CURLEY ST. BALTIMORE, MD.

29a. Certifier (Check only one): 1☐ **Certifying Phyeician**: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and manner es stated. 2☒ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and manner atated.

29b. Signature and title of certifier: Theodore M. King MD

29c. License number: O.C.M.E

29d. Date signed (Month, Dey, Year): JANUARY 21,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Year): JAN 25 2001

32. Registrar's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01762

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MILDRED WHITE

2. Date of Death — Month: JANUARY Day: 20 Year: 2001

3. Time of Death: 4:10 AM

4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-32-9994

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): APRIL 30, 1932

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2568 SALERNO PLACE

10f. Zip Code: 21230

10g. Citizen of What Country? USA.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10TH GRADE

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): WILLIAM SAMPLE

18. Mother's Name (First, Middle, Maiden Surname): GERTRUDE GUMBY

19a. Informant's Name/Relationship (Type, Print): DARLENE WATKINS (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2503 SOUTHDENE AVE., BALTO. MD. 21230

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS CEMETERY

Date: 01-26-01

20c. Location - City or Town, State: ARBUTUS, MARYLAND

21. Signature of Funeral Service Licensee: Robert A. Wilkins

22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE, BALTO. MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION — 30 minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

CORONARY ARTERY DISEASE

END STAGE RENAL DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gustavo Ros MD.

29c. License number: P14433

29d. Date signed (Month, Day, Year): 1/20/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GUSTAVO F. ROS MD HARBOR HOSPITAL CENTER BALTIMORE, MD.

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01763

Westcott, Patricia
Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PATRICIA RUTH WESTCOTT
2. Date of Death: Month JANUARY Day 23 Year 2001
3. Time of Death: 3:35AM
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 216-24-8983
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 3, 1929
9. Birthplace (State or Foreign Country): GA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 308 BAYLOR ROAD
10f. Zip Code: 21061
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): CHARLES M. MOROME
18. Mother's Name (First, Middle, Maiden Surname): MERLE TURNER

19a. Informant's Name/Relationship (Type, Print): JOHN G. WESTCOTT (HUSBAND)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 308 BAYLOR ROAD, GLEN BURNIE, MARYLAND 21061

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MEADOWRIDGE MEMORIAL PARK Date: 1/26/2001
20c. Location - City or Town, State: ELKRIDGE, MD.

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. DILATED CARDIOMYOPATHY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D45149
29d. Date signed (Month, Day, Year): JANUARY 23 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ONABAJO. B 301 HOSPITAL DRIVE GLEN BURNIE MD 21061

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

01-0359-005
CJ
Linda Wardell

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED# 23a,b,ptII,27 per ME G793 031301 SS

Certificate of Death

Reg. No. 2001 01764

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Linda K. Wardell

2. Date of Death — Month: January; Day: 21; Year: 2001

3. Time of Death: 10:26 P.M.

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital

4b. City, Town, or Location of Death: Essex

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-70-8547

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 41 Yrs.

If Under 1 Year — Months: ; Days: ; If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth (Month, Day, Year): March 12,1959

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 15 Paula Place

10f. Zip Code: 21237

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Companion

16b. Kind of Business/Industry: Elder Care

17. Father's Name (First, Middle, Last): Richard Alvin Wardell

18. Mother's Name (First, Middle, Maiden Surname): Grace Alene Graham

19a. Informant's Name/Relationship (Type, Print): Gary Greene/ Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 317 N. Earlton Road Havre De Grace, MD 21078

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory,Inc. Date: 1/25/01

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: ▶ [signature] M00982

22. Name and Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Drive Baltimore, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. CHRONIC NARCOTISM

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ASTHMA, SYSTEMIC LUPUS ERYTHEMATOSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? partial 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Dennis J Chuteo

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): January 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chuteo 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001

32. Registrar's Signature: ▶ Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01765

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): CHARLES WEBRECK
2. Dete of Deeth — Month: January Dey: 23 Year: 2001
3. Time of Death: 6:20 pm
4a. Facility Neme (If not institution, give street end number): GOOD SAMARITAN HOSPITAL
4b. City, Town, or Location of Deeth: BALTIMORE
4c. County of Deeth:

Funeral Director

5. Social Security Number: 213-22-3981
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 73 Yrs. — If Under 1 Yaar: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): 1/27/1927
9. Birthplece (Stete or Foreign Country): Maryland

Usuel Residence of Decedent

10a. Stete: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1324 Cedarcroft Road
10f. Zip Code: 21239
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Merried 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): — College (1-4or 5+): 2
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Auto Mechanic
16b. Kind of Business/Industry: Self Employed
17. Father's Neme (First, Middle, Last): Charles Ralph Webreck
18. Mother's Neme (First, Middle, Meiden Surneme): Edna Cornwell
19a. Informent's Neme/Relationship (Type, Print): Martha Elizabeth Webreck
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 1324 Cedarcroft Road Baltimore, Maryland 21239
20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Plece of Disposition (Neme of cemetery, cremetory or other plece): Moreland Memorial Cemetery — Dete: 1/26/01
20c. Location - City or Town, Stete: Baltimore, Maryland
21. Signeture of Funeral Service Licensee:
22. Neme end Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not anter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line. — Approximete Interval Between Onset and Deeth

Immedlete Ceuse (Finel disaese or condition resulting in deeth): a. SEPSIS

Due to (or es a consequence of): b. Pneumonia

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseesa or Injury that initieted events resulting in deeth) Last

Due to (or es e consequence of): c.

Due to (or es e consequanca of): d.

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: COPD

23b. Did tobacco uee contributa to the cause of death? 1☐ Yee 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one): Hospital: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer):
28b. Time of Injury: M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred:
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify):
28f. Location (Street and Number or Rural Route Number, City or Town, Stete):

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end manner es steted. 2☐ Medical Examiner: On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the ceuse(s) end manner steted.

29b. Signeture end Title of certifier: MD
29c. Licensa number: P13453
29d. Dete signed (Month, Dey, Yeer): January 23 2001

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): GONZALO GIANELLA MD . 5601 Loch Raven Blvd . Baltimore MD

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 24 2001
32. Registrer's Signeture:

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01766

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Peggy Laverne Walden
2. Date of Death Month Day Year: January 20, 2001
3. Time of Death: 7:00 p.m.
4a. Facility Name *(If not institution, give street and number)*: Chesapeake Hospice House
4b. City, Town, or Location of Death: Linthicum
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 382-32-0225
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 69 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 1/13/1932
9. Birthplace *(State or Foreign Country)*: Kentucky

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Millersville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 170 Hayden Road
10f. Zip Code: 21108
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Electronics Assembler
16b. Kind of Business/Industry: Aero-Space

17. Father's Name *(First, Middle, Last)*: Lee Edward LeCroy
18. Mother's Name *(First, Middle, Maiden Surname)*: Josie Duff

19a. Informant's Name/Relationship *(Type, Print)*: Gary Lee Walden (son)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9902 Britinay Lane, Carney, Maryland 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holly Hill Mem. Gardens
Date: 1/24/2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lung Cancer	2years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D38687
29d. Date signed *(Month, Day, Year)*: Jan. 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen Katz 139 OLD Solomon's Island Road Annapolis MD 21401

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 01767

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eileen Deal Wright

2. Date of Death (Month, Day, Year): January 23, 2001

3. Time of Death: 3:40 PM

4a. Facility Name (If not institution, give street and number): Stella Maris

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-34-5488

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): October 6,1912

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2300 Dulaney Valley Road Unit K-308

10f. Zip Code: 21093

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Wes Decedent of Hispanic Origin? (Specity Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementery/Secondery (0-12): 10th Grade
College (1-4or 5+): N/A

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Typist

16b. Kind of Business/Industry: Air Cond. & Refrig.

17. Father's Name (First, Middle, Last): William Henry Deal

18. Mother's Name (First, Middle, Maiden Surneme): Bertha Davern

19e. Informent's Neme/Relationship (Type, Print): Mary Teves/Friend

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2300 Dulaney Valley Rd. Apt. F-302 Timonium MD 21093

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Placa of Disposition (Neme of cemetery, cremetory or other piece): Hilltop Service Corp.

Date: 01/25/01

20c. Location - City or Town, State: Towson, Maryland

21. Signeture of Funerel Service Licensee: ▶ Paul L. Hartsock, Jr

22. Neme end Address of Fecility: Leonard J. Ruck, Inc. 5305 Harford Rd. Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feilure. List only one ceuse on each line.

Approximete Interval Between Onset and Death

Immediate Ceusa (Final disease or condition resulting in deeth)
a. Pneumonia — one week
Due to (or es a consequenca of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last
b.
Due to (or es e consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Placa of Deeth (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete and plece, and due to the ceuse(s) and manner stated.

29b. Signature end title of certifier: ▶ Marian Kowalewski MD

29c. License number: D21022

29d. Dete signed (Month, Day, Year): 1-24-01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): M. KOWALEWSKI MD 7672 BELAIR RD. BALTO MD. 21236

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001

32. Registrar's Signature: ▶ Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01768

WOLKENSTEIN, ZIGMUND

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ZIGMUND WOLKENSTEIN
2. Date of Death (Month, Day, Year): January 23, 2001
3. Time of Death: 01:36 am
4a. Facility Name (If not institution, give street and number): Sinai Hospital
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 427-49-5502
6. Sex: 1 XX M 2 ☐ F
7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEP. 6, 1945
9. Birthplace (State or Foreign Country): CANADA

Usual Residence of Decedent

10a. State: CANADA
10b. County: ONTARIO
10c. City, Town or Location: TORONTO
10d. Inside City Limits: 1 XX Yes 2 ☐ No
10e. Street and Number: 25 NORTHMOUNT AVENUE
10f. Zip Code: M3H-1N5
10g. Citizen of What Country?: CANADA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XX No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5+ College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): EXECUTIVE DIRECTOR
16b. Kind of Business/Industry: JEWISH PUBLIC LIBRARY

17. Father's Name (First, Middle, Last): CARL WOLKENSTEIN
18. Mother's Name (First, Middle, Maiden Surname): FAYE ZERNITSKY

19a. Informant's Name/Relationship (Type, Print): DONNA WOLKENSTEIN / WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 25 NORTHMOUNT AVENUE - TORONTO, ONTARIO, CANADA M3H-1N5

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): PARDES SHALOM CEMETERY
Date: 1/23/01
20c. Location - City or Town, State: TORONTO, CANADA

21. Signature of Funeral Service Licensee: Jay Fde
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Myocardial infarction — 3 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dr. Myechia Minter
29c. License number: RES-000
29d. Date signed (Month, Day, Year): January 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Myechia Minter Sinai Hospital

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature:

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01769

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GOLDIE WEINBERG
2. Date of Death Month/Day/Year: JANUARY 20, 2001
3. Time of Death: 5:00 PM
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218-09-0508
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAR 17 1915
9. Birthplace (State or Foreign Country): BALTO., MD.

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE CITY
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3906 LABYRINTH ROAD
10f. Zip Code: 21215
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): OWNER
16b. Kind of Business/Industry: GROCERY STORE

17. Father's Name (First, Middle, Last): JOSEPH SCHERR
18. Mother's Name (First, Middle, Maiden Surname): FANNIE (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print): RONALD WEINBERG/SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2409 FOREST GREEN ROAD BALTIMORE, MD. 21209

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HEBREW YOUNG MEN CONG. Date: 1/24/01
20c. Location - City or Town, State: WOODLAWN, MD.

21. Signature of Funeral Service Licensee: Scott M. Cutler
22. Name and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

Physician /Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	CARDIOGENIC SHOCK	2 HOURS
Due to (or as a consequence of): b.	ACUTE MYOCARDIAL INFARCTION	2 HOURS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	CORONARY ARTERY DISEASE	YEARS
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D47587
29d. Date signed (Month, Day, Year): JANUARY 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT FINE, MD, 5401 OLD COURT ROAD, RANDALLSTOWN, MD 21133

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature: Deanna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01770

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BETTY SIGEL WINNER
2. Date of Death Month Day Year: JAN 21 2001
3. Time of Death: 11AM
4a. Facility Name (If not institution, give street and number): PIKESVILLE NURSING HOME
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 219-30-4898
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 97 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN 5 1904
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11 SLADE AVE. APT. 805
10f. Zip Code: 21208
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4 or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NURSE
16b. Kind of Business/Industry: MEDICINE

17. Father's Name (First, Middle, Last): MEYER SIGEL
18. Mother's Name (First, Middle, Maiden Surname): REBECCA (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print): CHARLES WINNER/ SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4 RED BARN COURT BALTIMORE,MD. 21208

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HEBREW FRIENDSHIP
Date: 1/24/01
20c. Location - City or Town, State: BALTIMORE,MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Severe Organic Brain Syndrome — 5y.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Sepsis, hypothyroid, CVD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D16941
29d. Date signed (Month, Day, Year): 1/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Samuel E Benash 21 Crossroad Dr Owings Mills, md 21117

10

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature: [signature]

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01771

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Raymond George Ziegler

2. Data of Death Month Day Year: JANUARY 24, 2001

3. Time of Death: 06:45 AM

4a Facility Name *(If not institution, give street and number)*: Saint Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-16-8525

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Yaer: Months / Daya

If Undar 24 Hrs.: Hours / Min.

8. Deta of Birth *(Month, Day, Year)*: August 20, 1917

9. Birthplace *(Stata or Foraign Country)*: MD

Usual Residence of Decedant

10a. Stata: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 8314 Wilson Avenue

10f. Zip Coda: 21234

10g. Citizan of What Country?: USA

11. Marital Status: 1 [ ] Navar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedant Evar in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Giva Yaar or Datas: WWII

13. Was Decedent of Hispanic Origin? (Specify Yaa or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - American Indien, Black, White, etc. Specify: white

15. Decedant's Educetion *(Specify only highest grade completed)*: Elemantery/Secondary (0-12): 8 / Cottega (1-4or 5+):

16a. Decedant's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT use retired)*: Printer

16b. Kind of Busineas/Industry: Printing

17. Fathar'a Nama *(First, Middle, Last)*: George Ziegler

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Clara Meskill

19a. Informant's Name/Reletionahip *(Type, Print)*: Geraldine Ziegler - wife

19b. Meiling Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 8314 Wilson Avenue, Baltimore, MD 21234

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*

20b. Place of Disposition *(Nema of cematery, cramatory or othar piece)*: Parkwood Cemetery

Data: 1/26/01

20c. Location - City or Town, Stata: Baltimore, MD

21. Signature of Funaral Sarvice Licensee: [signature] MO0986

22. Nama and Address of Facility: CAFA, Stephen D. Lohrmann, P.A. 8717 Green Pastures Drive, Towson, MD 21286

Physician /Medical Examiner

23a. Part I. Entar tha diseese, or complications that caused the daeth. Do not antar the moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only one ceuse on aech lina.

Approximata Intarval Batween Onset and Deeth

Immediata Causa (Final disaase or condition rasulting tn death): a. CEREBROVASCULAR THROMBOSIS — 9 DAYS

Due to (or as a consequanca of):

Sequentially list conditions, if any, leeding to immadiata causa. Entar Undarlying Cause (Diaaaaa or injury that initiated evants rasulting in death) Last

b. Dua to (or as a consequanca of):

c. Due to (or aa e consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contributa to the causa of death? 1 [ ] Yaa 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Ware autopsy findings available prior to complation of ceuse of death? 1 [ ] Yas 2 [X] No

25. Wes cese rafarred to medical examnar? 1 [ ] Yas 2 [X] No

26. Placa of Deeth *(Check only ona)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Mannar of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Panding invastigation 6 [ ] Cauld not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, offica building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To tha best of my knowledga, death occurred at tha tima, deta and placa, and due to tha cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, death occurred at the time, deta and placa, and dua to the cause(s) and manner stated.

29b. Signatura and title of certifier: Beatriz P. Dizon, M.D.

29c. Licensa number: D 0016492

29d. Data signed *(Month, Day, Year)*: January 24, 2001

30. Nama and address of person who comptated causa of death (Item 23a) (Type, Print): BEATRIZ P. DIZON, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 25 2001

32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

55

10

Amended #3, MRS 1/10/01, Allegany Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01772

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGARET HELEN BECK
2. Date of Death Month 01 Day 05 Year 01
3. Time of Death ~~5:17~~ 5:50 AM
4a. Facility Name (If not institution, give street and number): SACRED HEART HOSPITAL
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 212-38-5560
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT 14 1914
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ALLEGANY
10c. City, Town or Location: LAVALE
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 523 NATIONAL HIGHWAY
10f. Zip Code: 21502
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+): 5
16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): ALLEGANY CO. BOARD OF EDUCATION
16b. Kind of Business/Industry: TEACHER

17. Father's Neme (First, Middle, Last): JOHN S.F. BECK
18. Mother's Name (First, Middle, Meiden Surneme): ELLEN C. BROWN

19e. Informant's Neme/Reletionship (Type, Print): KATHRYN B. BANDY SISTER
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 190 BARDIN ESTATES CIRCLE PALAKA, FLORIDA 32177

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): GREENMOUNT CEMETERY
Date: JAN 11 2001
20c. Location - City or Town, Stete: CUMBERLAND MARYLAND

21. Signature of Funerel Service Licensee: Dale L. Merritt
22. Neme end Address of Facility: MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Cause (Finel disease or condition resulting in deeth)
a. Bilateral Pneumonia — 3days
Due to (or as e consequence of):
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest
b.
Due to (or es a consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.
- Addison's Disease
- Hyperlemion

23b. Did tobecco use contributs to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown
24e. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Ptece of Deeth (Check only one): Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner steted.
29b. Signeture end title of certifier
29c. License number: D0033280
29d. Dete signed (Month, Day, Year): JANUARY 5, 2001

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): SUNIL GUPTA, M.D. 625 KENT AVE. CUMBERLAND, MD 21502

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 10 2001
32. Registrer's Signeture: Brenda B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10
Yes

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01773

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Alice Mae Beddle

2. Date of Death — Month: January Day: 15 Year: 2001

3. Time of Death: 9:40 AM

4a. Facility Name *(If not Institution, give street and number)*: Caroline Nursing Home

4b. City, Town, or Location of Death: Denton

4c. County of Death: Caroline

Funeral Director

5. Social Security Number: 222-09-1244

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 90 Yrs.

If Under 1 Year — Months: Days: If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: May 1, 1910

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residance of Decedent

10a. State: Maryland

10b. County: Caroline

10c. City, Town or Location: Goldsboro

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 15764 Meeks Road

10f. Zip Code: 21636

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*

Elamantary/Secondery (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: owner/operator

16b. Kind of Business/Industry: Retail

17. Father's Name *(First, Middle, Last)*: Charles Draper

18. Mother's Neme *(First, Middle, Maiden Surname)*: Mabel Walls

19a. Informent's Neme/Relationship *(Type, Print)*: William Beddle Jr son

19b. Meiting Addrass *(Street and Number or Rural Route Number, City or Town, Stata, Zip Coda)*: PO Box 33 Felton, Delaware 19943

20a. Method of Dispostion: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cemetery, crematory or other place)*: Greensboro Cemetery

Date: Jan 19 2001

20c. Location - City or Town, State: Greensboro, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Fleegle - Helfenbein Funeral Home PA PO Box 160 Greensboro, Maryland 21639

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errast, shock, or heart failure. List only ona causa on each lina.

Approximata Interval Between Onset end Deeth

Immedieta Cause (Final disease or condition resulting in daeth)

a. dementia — years

Due to (or es a consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last

b.

Due to (or as e consequence of):

c.

Due to (or as a consequence of):

d.

Part ff. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior to completion of cause of daeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Placa of Deeth *(Check only ona)*

Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigetion 6☐ Could not be determined

28e. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Plece of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, death occurred at tha tima, date and place, and dua to tha cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred et the tima, dete and place, and dua to the ceuse(s) end menner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D0047534

29d. Date signed *(Month, Day, Year)*: 1/15/01

30. Neme and address of person who completed causa of death (Item 23a) (Type, Print): Wafik Zaki MD 920 Market Street Denton, Maryland 21629

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 18 2001

32. Registrer's Signeture: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01774

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Paul Bittner
2. Date of Death (Month, Day, Year): January 6 2001
3. Time of Death: 7:10 AM
4a. Facility Name *(If not institution, give street and number)*: Sacred Heart Hospital
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 205-16-0898
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 25-Oct-26
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Allegany
10c. City, Town or Location: Frostburg
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 4 Maple Drive
10f. Zip Code: 21532-
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Musician
16b. Kind of Business/Industry: Music

17. Father's Name *(First, Middle, Last)*: Cyrus Bittner
18. Mother's Name *(First, Middle, Maiden Surname)*: Lela M. Caton

19a. Informant's Name/Relationship *(Type, Print)*: Nellie L. Bittner Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4 Maple Drive Frostburg Maryland 21532-

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Greenville Cemetery
Date: 09-Jan-01
20c. Location - City or Town, State: Greenville, Pennsylvania

21. Signature of Funeral Service Licensee: John R. Durst
22. Name and Address of Facility: Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	sepsis syndrome	2 days
Due to (or as a consequence of): b.	pneumonia	11 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner atated.

29b. Signeture end title of certifier: Wonsock Shin M.D.
29c. License number: D0055325
29d. Date signed *(Month, Day, Year)*: January 07 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WONSOCK SHIN MD 48 Tarn Terrace Suite 204 Frostburg, MD 21532

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 08 2001
32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01775

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RICHARD HOWARD BITTINGER

2. Date of Death (Month, Day, Year): JANUARY 5 2001

3. Time of Death: 7:05 AM

4a. Facility Name (If not institution, give street and number): CUMBERLAND NURSING HOME

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 212-18-1024

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG 30 1920

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: CUMBERLAND

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1029 FREDERICK STREET

10f. Zip Code: 21502

10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): ACME MARKET

16b. Kind of Business/Industry: FOOD MARKET

17. Father's Name (First, Middle, Last): CLARK FRANK BITTINGER

18. Mother's Neme (First, Middle, Maiden Surname): ROSELLA EMMA LIGHT

19a. Informant's Name/Reletionship (Type, Print): MARY JANE BITTINGER WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1029 FREDERICK STREET CUMBERLAND MARYLAND 21502

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): CUMBERLAND CREMATORY

Date: JAN 7 2001

20c. Location - City or Town, State: CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee: Dale L. Merritt

22. Neme and Address of Facility: MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in deeth) a. Coronary artery disease — 10 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D0033280

29d. Date signed (Month, Day, Year): Jan 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR SUNIL K. GUPTA 625 KENT AVENUE CUMBERLAND MARYLAND 21502

State Registrar

31. Date filed (Month, Day, Year): JAN 08 2001

32. Registrar's Signature: Regina B Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

9

MS

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01776

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VIRGINIA MARTIN BURTMAN

2. Date of Death: Month 01 Day 08 Year 01

3. Time of Death: 9:45 pm

4a. Facility Name (If not institution, give street and number): MALLARD BAY NURSING HOME

4b. City, Town, or Location of Death: CAMBRIDGE

4c. County of Death: DORCHESTER

Funeral Director

5. Social Security Number: 221-09-9399

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC. 11, 1914

9. Birthplace (State or Foreign Country): WEST VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: DORCHESTER

10c. City, Town or Location: CAMBRIDGE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7 SHADY DRIVE

10f. Zip Code: 21613

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): HOWARD MARTIN

18. Mother's Name (First, Middle, Maiden Surname): ALICE PRETTYMAN

19a. Informant's Name/Relationship (Type, Print): KAROLINE REDLINE - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7 SHADY DR CAMBRIDGE, MD 21613

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): CAMBRIDGE CREMATORY

Date: 1/10/01

20c. Location - City or Town, State: CAMBRIDGE, MARYLAND

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximata Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure — Weeks

Due to (or as a consequence of):
b. Cardiomyopathy — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Coronary artery Disease — Years

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Cerebrovascular accident

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Eugene Newmier DO

29c. License number: H51793

29d. Date signed (Month, Day, Year): 1/9/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Eugene Newmier DO 503 Byrn St Cambridge MD 21613

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001

32. Registrar's Signature: Penny B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

5 DQ

RKD

01-0236-021

ZACHARIAH

BARR AMEND ITEM 1,23a,27,28a-f per ME G795 050901 SS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2001 01777

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Zachariah	E.	Barr	JANUARY 14, 2001	11:05A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
90 WAVERLY DRIVE	FREDERICK	FREDERICK

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	If Under 1 Year: Days	If Under 24 Hrs.: Hours	If Under 24 Hrs.: Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-59-8546	1☒M 2☐F	0 Yrs.	2	6			Nov. 8, 2000	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
90 Waverly Drive Apt. JJ301	21701	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
0		N/A	N/A

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Eric M. Barr	Jessica Anne Dollard

19a. Informant's Neme/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Eric M. Barr/ Father	90 Waverly Drive Apt. JJ301 Frederick, MD 21701

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from Stete 4☐Donation 5☐Other (Specify)	Lakemont Meml. Gardens	1-18-01	Davidsonville, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in deeth)
e. POSITIONAL ASPHYXIA

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) SCENE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	1-14-01	found: 11:00 AM	1☐Yes 2☒No	subject pressed against mother & wall

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
residence	90 Waverly Dr., Frederick, Maryland

29e. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Theodore M. King MD	O.C.M.E.	JANUARY 15,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year)	32. Registrar's Signature
JAN 25 2001	▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01778

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Beulah Wright Conlon
2. Date of Death Month Day Year: January 5, 2001
3. Time of Death: 2040
4a. Facility Name *(If not institution, give street and number)*: Sacred Heart Hospital
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 217-10-1607
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jun 1, 1909
9. Birthplace *(State or Foreign Country)*: PA

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: Furnace Street Ext.
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Cosmetologist
16b. Kind of Business/Industry: Cosmetology

17. Father's Name *(First, Middle, Last)*: Edgar Bittner
18. Mother's Name *(First, Middle, Maiden Surname)*: Clara (Wright)

19a. Informant's Name/Relationship *(Type, Print)*: Gail Quick daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 501 Sailmaster;Hilton Head SC 29928

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Scarpelli Funeral Home
Date: 1/09/2001
20c. Location - City or Town, State: Cresaptown, MD

21. Signature of Funeral Service Licensee: ▶ James J Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis Syndrome — two days.

Due to (or as a consequence of):
b. Hyperosmolar coma. — Not known

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Diabetes — Not known

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Cerebrovaccular Accident

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Wonsock Shin M.D.
29c. License number: D0055325
29d. Date signed *(Month, Day, Year)*: January 06, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WONSOCK SHIN MD. 48 Tarn Terrace Suite 204 Frostburg, MD 21532

3

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001
32. Registrar's Signature: ▶ Deputy Registrar

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01779

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Victor Pearle Coffman

2. Date of Death Month Day Year: January 10, 2001

3. Time of Death: 9:12 p.m.

4a. Facility Name *(If not Institution, give street and number)*: 636 East First Street

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 723-09-0941

6. Sex: 1☐ M 2☐ F — X

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec 11, 1927

9. Birthplace *(State or Foreign Country)*: WV

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1☒ Yes 2☐ No — X

10e. Street and Number: 636 East First Street

10f. Zip Code: 21502

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — X

If Yes, Give Year or Date: 1945-70

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☐ No — X — Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Staff Sergeant

16b. Kind of Business/Industry: U.S. Air Force

17. Father's Name *(First, Middle, Last)*: Warden Jesse Coffman

18. Mother's Name *(First, Middle, Maiden Surname)*: Lillian D (Rinker)

19a. Informant's Name/Relationship *(Type, Print)*: Eleanor Coffman

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 636 East First Street;Cumberland MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)* — X

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rocky Gap Veterans Cem

Date: 1/16/2001

20c. Location - City or Town, State: Flintstone, MD

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. CA of the prostate with metastasis — 7 1/yrs.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. COPD — >5yrs.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Date of Injury *(Month, Day, Year)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Terry E. Williams

29c. License number: D16041

29d. Date signed *(Month, Day, Year)*: January 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Terry E. Williams, M.D.; Memorial Hospital Medical Bldg; Cumberland, MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001

32. Registrar's Signature: Geneva G Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

mv 12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01780

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Billy Joe Campbell
2. Date of Death: Month: January Day: 13 Year: 2001
3. Time of Death: 2054
4e. Facility Name (If not institution, give street and number): Union Hospital of Cecil County
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 234-66-5859
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 57 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): June 29, 1943
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: North East
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 103 Porter Road
10f. Zip Code: 21901
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Reca - American Indian, Bleck, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): Diagnostic Repairs
16b. Kind of Business/Industry: Auto - Chrysler

17. Fether's Nama (First, Middle, Last): Charlie Underwood
18. Mother's Name (First, Middle, Maiden Surneme): Lula Campbell

19e. Informant's Name/Relationship (Type, Print): Polly Campbell / Spouse
19b. Meiting Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 103 Porter Road, North East, Maryland 21901

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other place): North East Methodist Cemetery
Date: January 16, 2001
20c. Location - City or Town, Stata: North East, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Crouch Funeral Home, 127 South Main Street, North East, Maryland 21901

Physician /Medical Examiner

rgw

23a. Part1. Enter the disaase, or complications that caused tha death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart failure. List only one cause on aach line.

Approximate Interval Between Onsat end Deeth

Immediate Ceuse (Finel disease or condition resulting in death)
a. Carcinoma of Lung with metastasis — 10 dys
Due to (or as e consequenca of):
b. Thrombocytopenia (Dx) — 10 dys
Due to (or es e consequenca of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Thrombocytopenia Dx — 1 dy
Dua to (or as a consequance of):
d.

Part II. **Other signiftcant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24e. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings availebie prior to completion of causa of death? 1 [ ] Yes 2 [ ] No

25. Was casa rafarred to medicet examinar? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Mannar of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Tima of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, straat, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and pleca, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner steted.

29b. Signatura and title of certifier: [signature] MD
29c. License number: D04823
29d. Date signed (Month, Day, Year): 1/15/01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): JUI CHIH HSU 223 West main st Elkton Md 21921

State Registrar

31. Dete filed (Month, Dey, Year): JAN 16 2001
32. Registrer's Signature: [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

15

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01781

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Earl Taylor Cullum

2. Date of Death (Month, Day, Year): JAN 07 2001

3. Time of Death: 9 PM

4a. Facility Name *(If not institution, give street and number)*: 3465 Linchester Road

4b. City, Town, or Location of Death: Preston

4c. County of Death: Caroline

Funeral Director

5. Social Security Number: 214-14-8632

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 14, 1924

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Caroline

10c. City, Town or Location: Preston

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3465 Linchester Road

10f. Zip Code: 21655

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No. If Yes, Give Year or Dates: 1942-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Maintenance Supervisor

16b. Kind of Business/Industry: Community College

17. Father's Name *(First, Middle, Last)*: Walter Allen Cullum

18. Mother's Name *(First, Middle, Maiden Surname)*: Florence Daugherty

19a. Informant's Name/Relationship *(Type, Print)*: Earl L. Cullum/Cousin

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 199 England Creamery Road, North East, MD 21901

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Maryland Veterans Cem.

Date: 1/12/01

20c. Location - City or Town, State: Beulah, Maryland

21. Signature of Funeral Service Licensee: Leonard D. Zeller

22. Name and Address of Facility: Zeller Funeral Home, P. O. Box 207, 106 Main Street, East New Market, MD 21631

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. GUNSHOT WOUND TO HEAD — Instant

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DEPRESSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*: JAN 07 2001

28b. Time of Injury: 9 P M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: GUNSHOT WOUND TO HEAD

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: RESIDENCE

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 3465 Linchester Rd, Preston MD 21655

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: C. Jensen MD Deputy M.E.

29c. License number: D14664

29d. Date signed *(Month, Day, Year)*: Jan 11 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHRISTIAN E. JENSEN MD, PO BOX 690, PENTON MD 21629

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 01782

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN THOMAS DELBUSSO
2. Date of Death (Month, Day, Year): JANUARY 11, 2001
3. Time of Death: 3:05 AM
4a. Facility Name (If not institution, give street and number): 802 GEPHART DRIVE
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 219-56-9507
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 49 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG. 17 1951
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MD
10b. County: ALLEGANY
10c. City, Town or Location: CUMBERLAND
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 802 GEPHART DRIVE
10f. Zip Code: 21502
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MAINTENANCE CONTRACTOR
16b. Kind of Business/Industry: BUILDING MAINTENANCE

17. Father's Name (First, Middle, Last): DOMINEC JOHN DELBUSSO
18. Mother's Name (First, Middle, Meiden Surname): PEARL ANSEL

19a. Informent's Name/Relationship (Type, Print): ROSE M. CUSTER / SISTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13602 N. ORLEANS RD, LITTLE ORLEANS, MD 21766

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): ZION MEMORIAL PARK
Date: 01/15/2001
20c. Location - City or Town, Stete: CUMBERLAND, MD

21. Signature of Funeral Service Licensee: ▶ Gene A. Upchurch
22. Name and Address of Facility: UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediete Ceuse (Final disease or condition resulting in death)
a. Small Cell Cancer of the lung - Diffuse Metastasis one years
Due to (or as a consequenca of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the causa of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Deeth (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examinar:** On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ Wayne C Spiggle MD
29c. License number: D0011143
29d. Date signed (Month, Dey, Yeer): 1 - 11 - 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Wayne C Spiggle, MD - BMG - 912 Seton Dr. Cumberland, MD 21502

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

2

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01783

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FLORENCE E. DAVIS
2. Date of Death Month Day Year: JANUARY 1,2001
3. Time of Death: 0539 A.M.
4a. Facility Name *(If not institution, give street and number)*: SACRED HEART HOSPITAL
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 235-30-2051
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MAY 4,1919
9. Birthplace *(State or Foreign Country)*: WEST VIRGINIA

Usual Residence of Decedent

10a. State: MD
10b. County: ALLEGANY
10c. City, Town or Location: LAVALE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 10 RICHARD WAY
10f. Zip Code: 21502
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SELF-EMPLOYED
16b. Kind of Business/Industry: GROCERY STORE

17. Father's Name *(First, Middle, Last)*: DAVID DENT DAVIS
18. Mother's Name *(First, Middle, Maiden Surname)*: NOVELLA L. BOAL

19a. Informant's Name/Relationship *(Type, Print)*: LUCILLE N. DAVIS / SISTER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10 RICHARD WAY, LAVALE, MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: LAUREL HILL CEMETERY
Date: 1/16/01
20c. Location - City or Town, State: BARTON, MD

21. Signature of Funeral Service Licensee: ▶ Sheryl A. Upchurch
22. Name and Address of Facility: UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Renal Failure	2mo
Due to (or as a consequence of):	Diabetes	10yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: COPD Idiopathic Pulmonary Fibrosis Chronic Resp. Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and Title of certifier: ▶ Richard G. Schreiber MD
29c. License number: MD 26066
29d. Date signed *(Month, Day, Year)*: JANUARY 2 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 900 Seton Dr Cumberland MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 04 2001
32. Registrar's Signature: ▶ Geneva B Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

5

MD

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01784

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Muriel Yvonne Dunham

2. Date of Death (Month, Day, Year): January 12, 2001

3. Time of Death: 0215 a.m.

4a. Facility Name (If not institution, give street and number): Sacred Heart Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 216-30-7125

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 64 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 14, 1936

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 14310 Barton Blvd.

10f. Zip Code: 21502

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Oliver Drury

18. Mother's Name (First, Middle, Maiden Surname): Hilda Armstrong

19a. Informant's Name/Relationship (Type, Print): Stanley R. Dunham Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14310 Barton Blvd. Cumberland, MD 21502

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place): Restlawn Memorial Gardens

Date: 1/15/2001

20c. Location - City or Town, State: LaVale, MD

21. Signature of Funeral Service Licensee: ▶ S. Mark Sapp

22. Name and Address of Facility: Upchurch Funeral Home, P.A. 202 Greene St. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ACUTE Pulmonary Embolism — unknown

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CARCINOMATOSIS with ASCITES.

Diabetes Mellitus

ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☑ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ S. Chang M.D.

29c. License number: D25638

29d. Date signed (Month, Day, Year): January 12 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SATURNINA CHANG M.D 10701 New Design Creek S.W Suite 3 Frostburg Maryland 21532

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: ▶ Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

MRS
per Yvonne G.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01785

Physician /Medical Examiner

Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1. Decedent's Name *(First, Middle, Last)*: KEITH ALLEN DAVIS
2. Date of Death — Month: Jan; Day: 11; Year: 2001
3. Time of Death: 0903 AM
4a. Facility Name *(If not institution, give street and number)*: Union Hospital
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil
5. Social Security Number: 160-62-4883
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 31 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Apr. 21,1969
9. Birthplace *(State or Foreign Country)*: W.Grove, PA

Usual Residence of Decedent

10a. State: PA
10b. County: Lancaster
10c. City, Town or Location: Warwick Twp., Lititz
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 65 Brookfield Road
10f. Zip Code: 17543
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Navar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yas 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.): 1 [ ] Yas 2 [X] No *Specify:*
14. Race - American Indian, Black, Whita, etc. *Specify:* white
15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): — College (1-4or 5+): 5
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: choir & organ director
16b. Kind of Businass/Industry: church
17. Father's Name *(First, Middle, Last)*: Charles F. Davis
18. Mother's Neme *(First, Middle, Maiden Surname)*: Ruth Ann Wood
19a. Informant's Name/Relationship *(Type, Print)*: Kristie A. Davis
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 65 Brookfield Rd., Lititz, PA 17543
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [X] Ramoval from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Placa of Disposition *(Name of cemetery, crematory or other place)*: Lititz Moravian Cemetery
Date: 1/15
20c. Location - City or Town, State: Lititz, PA
21. Signature of Fugeral Service Licensee: CC0202 Russell J. Gofus
22. Name and Address of Facility: Kuzo & Gofus Funeral Home, Ltd. Kennett Square PA

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart leilure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
a. Single gun shot wound to head
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequenca ot):
c.
Dua to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [X] Yes 2 [ ] No
26. Piece of Deeth *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*
27. Menner of Death: 1 [ ] Netural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*: 01-10-01
28b. Time of Injury: 1600 M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: gunshot wound to head
28e. Piece of Injury - At home, ferm, street, factory, offica building, etc. *(Specify)*: woods
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*: Rt. 274 and Dressage Ct., Rising Sun, MD

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete and placa, and due to the cause(s) end menner as stated. 2 [X] **Medicat Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end pleca, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michele Campisi
29c. License number: D55893
29d. Date signed *(Month, Day, Year)*: JAN 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michele Campisi 300 Bow Street, Elkton MD 21921

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: Jessie B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 01786

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RUTH FRANKLIN

2. Date of Death Month / Dey / Year: January 10 2001

3. Time of Death: 7:25 PM

4a. Facility Name *(If not institution, give street and number)*: SACRED HEART HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 212-38-7313

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 95 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JAN 3 1906

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: CUMBERLAND

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 220 WALLACE STREET

10f. Zip Code: 21502

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+): 5

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ALLEGANY CO. BOARD OF EDUCATION

16b. Kind of Business/Industry: SCHOOL TEACHER

17. Father's Name *(First, Middle, Last)*: JOHN L. FRANKLIN

18. Mother's Name *(First, Middle, Maiden Surname)*: ANNA JACKSON

19a. Informant's Name/Relationship *(Type, Print)*: SPURGEON WASHINGTON NEPHEW

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3687 FOREST HILL ROAD BALTIMORE MD. 21207-6344

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: WOODLAWN CEMETERY

Data: JAN 15, 2000

20c. Location - City or Town, State: CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee: Dale L. Merritt

22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory arrest — one day

Due to (or as a consequence of):

b. Acute pneumonitis — one week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

hypernatremia, dehydration

hypertension, peripheral vascular disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Shiv Khanna

29c. License number: D54004

29d. Date signed *(Month, Day, Year)*: January 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Shiv Khanna ,M.D. 625 Kent Avenue Cumberland MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01787

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Elsie Fehl

2. Date of Death: Month: Jan; Day: 8; Year: 01

3. Time of Death: 21:40

4a. Facility Name *(If not institution, give street and number)*: Calvert Manor Nursing Home

4b. City, Town, or Location of Death: Rising Sun

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 222-36-5721

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 92 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 23 1908

9. Birthplace *(State or Foreign Country)*: Germany

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Rising Sun

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1881 Telegraph Road

10f. Zip Code: 21911

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Jake Miller

18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Maier

19a. Informant's Name/Relationship *(Type, Print)*: Elizabeth Newberry

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2 Battle Drive Newark, DE 19702

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hockessin Crematory Co.

Date: January 11, 2001

20c. Location - City or Town, State: Hockessin, Delaware

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Chandler Funeral Home 2506 Concord Pike Wilmington, DE 19803

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Cerebrovascular Accident	5 days
Due to (or as a consequence of): b.	A.S.C.V.D.	3 yrs.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D-11115

29d. Date signed *(Month, Day, Year)*: Jan 8 - 01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Neil R Taylor Jr MD Calvert Healthcare Center Rising Sun, MD 21911

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001

32. Registrar's Signature: ▶ B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

6

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01788

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Franklin Lee Green
2. Date of Death Month Day Year: JAN. 12, 2001
3. Time of Death: 11:00PM
4a. Facility Name *(If not institution, give street and number)*: 4063 Payne Road
4b. City, Town, or Location of Death: Preston
4c. County of Death: Caroline

Funeral Director

5. Social Security Number: 220-26-2717
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jul.7,1921
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Caroline
10c. City, Town or Location: Preston
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 4063 Payne Road
10f. Zip Code: 21655
10g. Citizan of What Country?: United States

11. Maritel Stetus: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: '42-46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No *Specify:*
14. Race - American indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elamantary/Secondary (0-12): 9 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Farm Worker
16b. Kind of Businass/Industry: Agriculture

17. Father's Name *(First, Middle, Last)*: William Medford Green
18. Mother's Name *(First, Middle, Maidan Surname)*: Nora Jane Friend

19a. Informant's Name/Relationship *(Type, Print)*: Carol V. Green/Spouse
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4063 Payne Road, Preston, MD 21655

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, cramatory or other place)*: Eastern Shore Vet.
Dete: 1/16/01
20c. Location - City or Town, State: Hurlock, Maryland

21. Signature of Funaral Service Licensee: ▶ Michael F. Eskow
22. Name and Address of Facility: Framptom-Hawkins-Eskow Funeral Home, PA PO Box 43, Federalsburg, MD 21632

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in death) a.	Myocardial Infarction	2 years
Due to (or as a consequanca of): b.	Congestive Heart failure	2 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest — Due to (or as a consequence of): c.	Aortic stenosis	5 years
Due to (or as e consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the causa of death?** 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: ▶ MD
29c. License number: D0051132
29d. Date signed *(Month, Day, Year)*: 1-16-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jorge H. Abrego, M.D., PO Box 400, Denton, MD 21629

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: ▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01789

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BEULAH HUTCHESON

2. Date of Death (Month, Day, Year): January 11, 2001

3. Time of Death: 16:40

4a. Facility Name (If not institution, give street and number): SACRED HEART HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 433-54-2185

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPT 26, 1908

9. Birthplace (State or Foreign Country): WEST VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND | 10b. County: ALLEGANY | 10c. City, Town or Location: CUMBERLAND | 10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 951 SETON DR. APT 3 | 10f. Zip Code: 21502 | 10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SCHOOL TEACHER

16b. Kind of Business/Industry: EDUCATION

17. Father's Name (First, Middle, Last): SHAFER LARGENT

18. Mother's Name (First, Middle, Meiden Surname): EDITH KLEIN

19a. Informant's Name/Relationship (Type, Print): THOMAS HUTCHESON-NEPHEW

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 105 E. RING FACTORY RD, BEL AIR, MD 21014

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): SILBAUGH CREMATORY | Date: JAN 13, 2001

20c. Location - City or Town, State: UNIONTOWN, PA

21. Signature of Funeral Service Licensee: Douglas S Hafer

22. Name and Address of Facility: HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY, LAVALE, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediete Ceuse (Finel disaasa or condition resulting in death)	Acute Congestive heart failure	10 days
Due to (or es e consequenca of):		
b.	Arteriosclerotic heart Disease	40 years
Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest — Due to (or as a consequence of):		
c.		
Dua to (or es a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal failure, Sepsis, Urosepsis, Pneumonia, hepatorenal Syndrome, old age, C.V.A. old, Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S L Sandhir MD

29c. Licensa number: D14464

29d. Date signed (Month, Day, Year): January 12, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): DR. S.L. SANDHIR, 48 TARN TERRACE, FROSTBURG, MD 21532

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

8

MHS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01790

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HELEN K. HOUCK

2. Date of Death Month / Day / Year: JAN 14 2001

3. Time of Death: 12:15 PM

4e. Facility Name *(If not institution, give street and number)*: ALLEGANY COUNTY NURSING HOME

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 193-05-6103

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: OCT 14, 1909

9. Birthplace *(State or Foreign Country)*: PENNSYLVANIA

Usual Residence of Decedent

10a. State: MARYLAND | 10b. County: ALLEGANY | 10c. City, Town or Location: CUMBERLAND | 10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 730 FURNACE STREET | 10f. Zip Code: 21502 | 10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): UNKNOWN | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOUSEKEEPER

16b. Kind of Business/Industry: NURSING HOME

17. Father's Name *(First, Middle, Last)*: ALEXANDER KRUCZEWSKI

18. Mother's Name *(First, Middle, Maiden Surname)*: AMELIA NOVICKI

19a. Informant's Name/Relationship *(Type, Print)*: HELEN K. HOUCK-SELF

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 730 FURNACE ST., CUMBERLAND, MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ST. JOSEPH CATHOLIC CHURCH CEMETERY | Date: JAN 17, 2001

20c. Location - City or Town, State: COUPON, PA

21. Signature of Funeral Service Licensee: Douglas S Hafer

22. Name and Address of Facility: HAFER CHAPEL OF THE H ILLS MORTUARY 1302 NATIONAL HWY, LAVALE, MD 21502

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute CONGESTIVE HEART FAILURE — ONE YR

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE — ONE YR

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Roberto Barrera Jr

29c. License number: D-14865

29d. Date signed *(Month, Day, Year)*: JAN 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. R BARRERA MEM. HOSPITAL MED BLDG, CUMBERLAND, MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

01-0109-015
CJ
Clara Mae Hammer

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item 26 (6), 1/10/01, Cecil Co., bam

Certificate of Death

Reg. No. 2001 01791

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Clara Mae Hammer	January	07	2001	08:55 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
8 Shiloh Drive	Elkton	Cecil

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-38-6569	1☐M 2☒F	64 Yrs.					DEC 26, 1936	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Cecil	Elkton	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8 Shiloh Drive	21921	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)		
10		Assistant	Laboratory

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Ward World Wilmer	Goldie Eaton

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Bonnie S. McClelland/Daughter	149 Edge Avenue, New Castle, Delaware 19720

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	R.A. Ferris & Co. Inc.	1/10/01	West Chester, PA

21. Signature of Funeral Service Licensee: John E. Hess

22. Name and Address of Facility: Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Arteriosclerotic Cardiovascular Disease and	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. X Chronic Peptic Ulcer Disease	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: possible seizure disorder

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Inspection 1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) (Scene)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☐**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J. Laron Locke M.D.	O.C.M.E.	January 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 10 2001	B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01792

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Timothy Michael Howell
2. Date of Death (Month, Day, Year): January 10, 2001
3. Time of Death: 9:05 p.m.
4a. Facility Name (If not institution, give street and number): 204 Barnes Corner Road
4b. City, Town, or Location of Death: Rising Sun
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 212-78-4030
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 38 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 4, 1962
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Rising Sun
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 204 Barnes Corner Road
10f. Zip Code: 21911
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1981
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): House Painter
16b. Kind of Business/Industry: Painting Residential/Commercial

17. Father's Name (First, Middle, Last): Ballard L. Howell
18. Mother's Name (First, Middle, Maiden Surname): Ruth Kay Reed

19a. Informant's Name/Relationship (Type, Print): Ballard & Kay Howell
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 204 Barnes Corner Road, Rising Sun, MD 21911

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Brookview Cemetery
Date: 1-13-01
20c. Location - City or Town, State: Rising Sun, Maryland

21. Signature of Funeral Service Licensee: Richard L. Goodie
22. Name and Address of Facility: R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	AIDS	5 yrs
Due to (or as a consequence of): b.	Anemia	1 yr
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Cytomegalovirus Gastrointestinal	3 yrs
Due to (or as a consequence of): d.	Cytomegalovirus Retinitis	1 yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Wasting Syndrome; Bilateral Aseptic Necrosis Hips

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: James F. Ley MD
29c. License number: D43198
29d. Date signed (Month, Day, Year): 1/11/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James Ley, M.D. 1941 Limestone Road, Wilmington, DE 19808

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001
32. Registrar's Signature: Geneva G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01793

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward C. Hay
2. Date of Death (Month, Day, Year): January 13, 2001
3. Time of Death: 2:00 AM
4a. Facility Name (If not institution, give street and number): 2 Valley Forge Drive
4b. City, Town, or Location of Death: North East
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 314-05-8652
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 10, 1915
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: North East
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2 Valley Forge Drive
10f. Zip Code: 21901
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: 05/19/44 - 12/03/45
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Quality Control/Civil Service
16b. Kind of Business/Industry: United States Government

17. Father's Name (First, Middle, Last): Martin L. Hay
18. Mother's Name (First, Middle, Maiden Surname): Anna Strouse

19a. Informant's Name/Relationship (Type, Print): Linda L. Pugh / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2 Valley Forge Drive, North East, Maryland 21901

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): High View Memorial Gardens | Date: January 15, 2001
20c. Location - City or Town, State: Fallston, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Crouch Funeral Home, 127 South Main Street, North East, Maryland 21901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: D0047711
29d. Date signed (Month, Day, Year): January 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID GAR-EL 3 MALDIN AVENUE NORTH EAST MARYLAND 21901

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

r9W

12+1VA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01794

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary M. Jefferys

2. Data of Death Month Day Year: January 6, 2001

3. Time of Death: 2:15 AM

4a. Facility Name *(If not institution, give street and number)*: Calvert County Nursing Center

4b. City, Town, or Location of Death: Prince Frederick

4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 213-22-3289

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 91 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Sept. 18, 1909

9. Birthplaca *(State or Foraign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Calvert

10c. City, Town or Location: Prince Frederick

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 4920 Honey Cove Lane

10f. Zip Coda: 20678

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas: X

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify: X

14. Race - Amarican Indian, Black, Whita, atc. Specify: White

15. Decedent's Education *(Specify only highast grada complatad)*: Elementary/Secondary (0-12): Unknown; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: Homemaker

16b. Kind of Business/Industry: Home

17. Fathar's Nama *(First, Middla, Last)*: Harry T. Burke

18. Mother's Nama *(First, Middla, Maidan Surnama)*: Anna E. Droppleman

19a. Informant's Name/Ralationship *(Type, Print)*: Arvel E. Burke / Nephew

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 4920 Honey Cove Lane, Prince Frederick, MD 20678

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cematery, crematory or othar place)*: Sunset Memorial Park

Data: 1/10/2001

20c. Location - City or Town, Stata: Cumberland, MD

21. Signature of Funeral Service Licensee: [signature] H01095

22. Nama and Addrass of Facility: Upchurch Funeral Home, P.A. 202 Greene St., Cumberland, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the diseasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only ona causa on aach lina.

Approximata Interval Between Onsat and Death

Immediate Cause (Finel disaasa or condition resulting in death)
a. Cardiopulmonary Arrest
Dua to (or as a consequence of):
b. Malnutrition

Sequentially list conditions, if any, leading to immadiate causa. Entar Underlying Causa (Disaasa or injury that initiated evants resulting in death) Last
Dua to (or as a consequance of):
c. Alzheimers Dementia
Dua to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Wara autopsy findings available prior to compiation of cause of daath? 1☐ Yas 2☐ No

25. Was case refarrad to medical examinar? 1☐ Yas 2☑ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Homa 5☐ Rasidanca 6☐ Othar *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurrad

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☑ **Certifying Physician:** To tha bast of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of axaminetion and/or invastigetion, in my opinion, deeth occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar statad.

29b. Signature and Title of certifier: [signature] M.D.

29c. Licansa number: D55027

29d. Data signed *(Month, Day, Year)*: Jan 6th, 2001

30. Nama and address of person who complatad causa of death (Item 23a) (Type, Print): Manoj Panwala, M.D. 110 Hospital Road Suite # 303 Prince Frederick, MD 20678

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 09 2001

32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

5

MD

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01795

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Leroy Richard Jenkins
2. Date of Death Month Day Year: January 10, 2001
3. Time of Death: 11:30 p.m.
4a. Facility Name *(If not institution, give street and number)*: 1425 Magnolia Court
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 214-05-5641
6. Sex: 1☐ M 2☐ F — X
7. Age *(In yrs. last birthday)*: 90 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sep 25, 1910
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1☐ Yes 2☐ No — X
10e. Street and Number: 1425 Magnolia Court
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☐ No — X — Specify:
14. Race - American Indian, Bieck, White, etc. — Specify: white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 12; College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done dunng most of working life. DO NOT use retired)*: Laborer
16b. Kind of Business/Industry: Texaco Oil Co.

17. Fether's Neme *(First, Middle, Last)*: Joseph T. Jenkins
18. Mother's Neme *(First, Middle, Meiden Surneme)*: Eliza S (Brown)

19a. Informent's Neme/Reiationship *(Type, Print)*: Jeanette L. Layman daughter
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 14 Blackiston Avenue;Cumberland MD 21502

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)* — X
20b. Piece of Disposition *(Name of cemetery, cremetory or other place)*: Sunset Memorial Park
Dete: 1/13/2001
20c. Location - City or Town, Stete: Cumberland, MD

21. Signetore of Funerel Service Licensee: Michael J. Scarpelli
22. Name and Address of Feciiity: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervei Between Onset end Death

Immediete Ceuse (Finei diseese or condition resulting in death): a. CEREBROVASCULAR ACCIDENT — 5 YRS

Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or es a consequence of):

d.

JAN 11 2001

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

CHRONIC RENAL INSUFFICIENCY

CHRONIC ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to compietion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? released — 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Neturei 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Couid not be determined

28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) and menner steted.

29b. Signature and title of certifier: Robustiano Barrera
29c. License number: D14865
29d. Date signed *(Month, Day, Year)*: January 11th, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robustiano Barrera, M.D.; Memorial Hospital Medical Bldg; Cumberland, MD 21502

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 12 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 01796

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Kenneth Wayne Kirk

2. Date of Death (Month, Day, Year): JANUARY 8, 2001

3. Time of Death: 2034

4a. Facility Name *(If not institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 215-62-1917

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 47 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 7/3/1953

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 3985 Trace Hollow Run

10f. Zip Code: 21804

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1971-73

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Assembly Line Worker

16b. Kind of Business/Industry: Microwave Filter Manufacturing

17. Father's Name *(First, Middle, Last)*: Kenneth William Kirk

18. Mother's Name *(First, Middle, Maiden Surname)*: Helen Gail Teter

19a. Informant's Name/Relationship *(Type, Print)*: Hope Kirk-Thornton / Sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3985 Trace Hollow Run, Salisbury, MD 21804

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Crematory of Delmarva

Date: 1/09/2001

20c. Location - City or Town, State: Delmar, Delaware

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Short Funeral Home, 13 E. Grove Street, Delmar, DE 19940

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Anoxic Encephalopathy

Due to (or as a consequence of):

b. CHF

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Obesity

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D0054879

29d. Date signed *(Month, Day, Year)*: 1/9/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 106 Milford St Salisbury MD 21804

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

KENNETH KIRK 215-62-1917

15+1VA DQ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01797

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HENRY DWYRE KINNAMAN, SR.

2. Date of Death (Month, Day, Year): JANUARY 13, 2001

3. Time of Death: 9:20 AM

4a. Facility Name (If not institution, give street and number): WALDORF HEALTH CARE CENTER

4b. City, Town, or Location of Death: WALDORF

4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 577-12-5787

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPTEMBER 28, 1907

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: CHARLES

10c. City, Town or Location: WALDORF

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4140 OLD WASHINGTON RD

10f. Zip Code: 20604

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): WAREHOUSE SUPERINTENDENT

16b. Kind of Business/Industry: FURNITURE

17. Father's Name (First, Middle, Last): HENRY DWYRE KINNAMAN

18. Mother's Name (First, Middle, Maiden Surname): ORA HARRON

19a. Informant's Name/Relationship (Type, Print): HENRY D. KINNAMAN/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10602 GATOR COURT, CLINTON, MD 20735

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): WASHINGTON NATIONAL

Date: 1/16/2001

20c. Location - City or Town, State: SUITLAND, MARYLAND

21. Signature of Funeral Service Licensee: JOHN P. KNISLEY M01164

22. Name and Address of Facility: THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604-0156

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ATHERO - SCLEROTIC HEART DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ABDOMINAL AORTIC ANEURYSM
HYPERTENSION
CHARCOT MARIE TOOTH DISEASE
EDEMA LEGS AND ULCER

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: V. Anmangandla

29c. License number: D26064

29d. Date signed (Month, Day, Year): 01-13-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): V. SAGAR ANMANGANDLA, M.D., RT 5 & GOLDEN BEACH RD., P.O. BOX 282, CHARLOTTE HALL, MARYLAND 20622

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

JPK

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01798

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Debra Kay Logsdon
2. Date of Death: Month January Day 5 Year 2001
3. Time of Death: 1530
4a. Facility Name (If not institution, give street and number): Sacred Heart Hospital
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 214-86-4840
6. Sex: 1☐ M X☐ F
7. Age (In yrs. last birthday): 29 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sep 24, 1971
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: LaVale
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 11006 Dakota Avenue
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): none
16b. Kind of Business/Industry: none

17. Father's Name (First, Middle, Last): William L. Logsdon
18. Mother's Name (First, Middle, Maiden Surname): Judy A (Spence)

19a. Informant's Name/Relationship (Type, Print): William Logsdon father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11006 Dakota Avenue; LaVale MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Pleasant Grove Cemeter
Date: 1/08/2001
20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Acute Respiratory failure — 2 hr. 12 hr
Due to (or as a consequence of):
b. Aspiration — 12 hr
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. severe disease — 20 yrs
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Severe C.P

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Lavania MD
29c. License number: D0008377
29d. Date signed (Month, Day, Year): January 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR Uriel Velandia - 924 Seton Drive, Cumberland, MD 21502

State Registrar

31. Date filed (Month, Day, Year): JAN 08 2001
32. Registrar's Signature: Barbara G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

3
765

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01799

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GLADYS LORD

2. Date of Death (Month, Day, Year): JAN 15 2001

3. Time of Death: 2:45AM

4a. Facility Name (If not institution, give street and number): CAROLINE NURSING HOME

4b. City, Town, or Location of Death: DENTON

4c. County of Death: CAROLINE

Funeral Director

5. Social Security Number: 215 05 1436

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG 23, 1913

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD

10b. County: CAROLINE

10c. City, Town or Location: FEDERALSBURG

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 608 OLD DAYTON RD

10f. Zip Code: 21632

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE

16b. Kind of Business/Industry: HOUSE WIFE

17. Father's Name (First, Middle, Last): HENRY HARRISON TRICE

18. Mother's Name (First, Middle, Maiden Surname): MAE PENNYPACKER

19a. Informent's Neme/Relationship (Type, Print): LINDA HARRISON - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 22690 HAVERCAMP Rd. PRESTON MD

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): HILLCREST CEMETERY

Date: 01/17/01

20c. Location - City or Town, State: FEDERALSBURG, MD.

21. Signeture of Funeral Service Licensee: [signature]

22. Name and Address of Facility: WILLIAMSON FUNERAL HOME FEDERALSBURG MD. 21632

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediete Cause (Finel diseese or condition resulting in death)

a. Alzheimer's dementia — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

recurrent aspiration pneumonea

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: [signature] M.D.

29c. License number: D0047534

29d. Date signed (Month, Day, Year): 1/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WAFIK ZAKI 920 MARKET ST. DENTON, MD. 21629

State Registrar

31. Dete filed (Month, Day, Year): JAN 17 2001

32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 01800

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jessie Elizabeth Lyle
2. Date of Death (Month, Day, Year): Jan. 13 2001
3. Time of Death: 12:40AM
4a. Facility Name (If not institution, give street and number): Homestead Manor
4b. City, Town, or Location of Death: Denton
4c. County of Death: Caroline

Funeral Director

5. Social Security Number: 511-12-7113
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov.12,1913
9. Birthplace (State or Foreign Country): Kansas

Usual Residence of Decedent

10a. State: Texas
10b. County: Angelina
10c. City, Town or Location: Huntington
10d. Inside City Limits: ☒ Yes 2☐ No
10e. Street and Number: Viking Cove RR1
10f. Zip Code: 75949
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☒ Yes 2☐ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Family

17. Father's Name (First, Middle, Last): Jesse Campbell
18. Mother's Name (First, Middle, Maiden Surname): Gertrude Mabry

19a. Informant's Name/Relationship (Type, Print): Elizabeth Duddleston/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2235 SanJacinto Dr.,Kerrville,Tx78028

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Capitol Crematory
Date: 1/14/01
20c. Location - City or Town, State: Dover, De.

21. Signature of Funeral Service Licensee: Randolph P. Moore
22. Name and Address of Facility: Moore Funeral Home, P.A. 12 S. 2nd St., Denton, Maryland 21629

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert failure. List only one cause on each line. (Approximate Intervel Between Onset and Deeth)

Immediate Cause (Final disease or condition resulting in death): a. Sepsis
Due to (or as a consequence of):
b. Malnutrition
Due to (or as a consequence of):
c. Dehydration
Due to (or as a consequence of):
d. Alzheimer's Dementia, End Stage

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Homestead Manor
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature end title of certifier: Patricia J. Karnes Asst DO
29c. License number: H0056873
29d. Date signed (Month, Day, Year): 01/13/2001

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print): Patricia J. Karnes, DO 215 Old Town Rd.,Goldsboro, Md. 21636

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Bonnie L. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01801

THELMA LANNON 214-07-1183

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thelma G. Lannon

2. Date of Death Month Day Year: JANUARY 11 2001

3. Time of Death: 11:15 AM

4a. Facility Name (If not institution, give street and number): Memorial Hospital & Medical Center

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 214-07-1183

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb 10, 1913

9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 707 Haddon Avenue

10f. Zip Code: 21502

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): unknown

18. Mother's Name (First, Middle, Maiden Surname): Mabel (O'Neal)

19a. Informant's Name/Relationship (Type, Print): Carol J. Lloyd daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 707 Haddon Avenue; Cumberland MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Restlawn Memorial Gard

Date: 1/13/2001

20c. Location - City or Town, State: LaVale, MD

21. Signature of Funeral Service Licensee: James J Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Congestive Heart Failure — 10 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Arteriosclerotic Heart Disease — 5 years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robustiano Barrera Jr

29c. License number: D0014865

29d. Date signed (Month, Day, Year): JANUARY 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. ROBUSTIANO BARRERA, MEMORIAL HOSPITAL MEDICAL BLDG., CUMBERLAND, MD 21502

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: Penny B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01802

DANIEL LEWIS 214-07-5131

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name *(First, Middle, Last)*: Daniel Richard Lewis			2. Date of Death Month: JANUARY Day: 13 Year: 2001	3. Time of Death: 8:10 AM
4a. Facility Name *(If not institution, give street and number)*: Memorial Hospital & Medical Center	4b. City, Town, or Location of Death: Cumberland	4c. County of Death: Allegany		
5. Social Security Number: 214-07-5131	6. Sex: 1☐M 2☐F X	7. Age *(In yrs. last birthday)*: 86 Yrs.	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Mar 9, 1914	9. Birthplace *(State or Foreign Country)*: MD			

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Allegany	Cumberland	1☐Yes 2☐No X

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10 N. Liberty Street	21502	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married X 3☐Widowed 4☐Divorced	1☐Yes 2☒No X If Yes, Give Year or Dates:	1☐Yes 2☐No X Specify:	Specify: white

15. Decedent's Education *(Specify only highest grade completed)*		16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Bobbin Dept.	Textile

17. Father's Name *(First, Middle, Last)*	18. Mother's Name *(First, Middle, Maiden Surname)*
Edward Lewis	Sarah unk

19a. Informent's Name/Reletionship *(Type, Print)*	19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*
Betty Lewis Wife	10 N. Liberty Street;Cumberland MD 21502

20a. Method of Disposition	20b. Place of Disposition *(Name of cemetery, crematory or other place)*	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*	Mt. Hermon Cemetery	1/16/ 2001	Cumberland, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Nicholas J. Scarpelli	Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediete Cause (Finel diseese or condition resulting in death)

a. Pneumonia — < one week

Due to (or as a consequenca of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b. ____

Due to (or as e consequenca of):

c. ____

Due to (or as a consequence of):

d. ____

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death *(Check only one)*	
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death	28a. Date of Injury *(Month, Day Year)*	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed *(Month, Day, Year)*
▶ for Dr Lamm	D16041	JANUARY 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TERRY WILLIAMS, MEMORIAL HOSPITAL MEDICAL BUILDING, CUMBERLAND, MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*	32. Registrar's Signature
JAN 16 2001	▶ for G Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01803

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MILDRED ELIZABETH LONG
2. Date of Death (Month, Day, Year): January 11 2001
3. Time of Death: 1:50 pm
4a. Facility Name *(If not institution, give street and number)*: Mallard Bay Care Center
4b. City, Town, or Location of Death: Cambridge
4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 214-32-6569
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 92 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 27, 1908
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Dorchester
10c. City, Town or Location: Cambridge
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2023 Dailsville Rd.
10f. Zip Code: 21613
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11; College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: registered nurse
16b. Kind of Business/Industry: health care

17. Father's Name *(First, Middle, Last)*: Frank Barnett
18. Mother's Name *(First, Middle, Maiden Surname)*: Annabelle Holland

19a. Informant's Name/Relationship *(Type, Print)*: Richard B. Long - son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2025 Dailsville Rd., Cambridge MD 21613

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cambridge Cemetery — Date: 1-13-2001
20c. Location - City or Town, State: Cambridge, Md.

21. Signature of Funeral Service Licensee: ▶ Kenneth R. Thomas Jr.
22. Name and Address of Facility: Thomas Funeral Home PA, 700 Locust St. Cambridge MD 21613

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Congestive Heart failure — 2 weeks
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Kyphoscoliotic Cardiopulmonary Disease — 15 years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Alzheimer's Dementia; Ischemic Ulcers, Lower extremities

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D11284
29d. Date signed *(Month, Day, Year)*: 01.12.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANN R. WILKE, MD 400 MARYLAND AVE., CAMBRIDGE, MD 21613

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01804

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Loren K. Morrison
2. Date of Death Month Day Year: Jan. 7, 2001
3. Time of Death: 11:14 a.m.
4a. Facility Name *(If not institution, give street and number)*: 15708 Downing Street S.W.
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 232-50-8493
6. Sex: 1☐M 2☐F X
7. Age *(In yrs. last birthday)*: 68 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan 10, 1932
9. Birthplace *(State or Foreign Country)*: WV

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1☒Yes 2☐No X
10e. Street and Number: 15708 Downing Street SW
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married X 3☐Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Yeer or Dete: Korean
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐Yes 2☐No X *Specify:*
14. Rece - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: engineer technician
16b. Kind of Business/Industry: Gas Transmission

17. Father's Name *(First, Middle, Last)*: Opha E. Morrison
18. Mother's Name *(First, Middle, Meiden Surname)*: Rosalie (Luzeder)

19a. Informant's Name/Reletionship *(Type, Print)*: Willa Morrison wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 15708 Downing St S.W.;Cumberland MD 21502

20a. Method of Disposition: 1☐Burial 2☒Cremetion 3☐Removel from State 4☐Donetion 5☐Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other place)*: Scarpelli Funeral Home
Date: 1/08/2001
20c. Location - City or Town, State: Cresaptown, MD

21. Signature of Funeral Service Licensee: ▶ Nicholas J. Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart fellure. List only one ceuse on each line.

Approximate Interval Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in deeth)
a. Metastatic Melanoma — 2 ½ Years
Due to (or as a consequence of):

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initieted events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was en eutopsy performed? 1☐Yes 2☒No
24b. Were eutopsy findings svailable prior to completion of cause of death? 1☐Yes 2☐No

25. Was cese referred to medicel examiner? 1☐Yes 2☒No

26. Place of Deeth *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Panding investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, data and piece, end due to the ceuse(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the ceuse(s) and menner stated.

29b. Signeture and title of certifier: ▶ John Mehanna MD
29c. License number: D17526
29d. Date signed *(Month, Day, Year)*: Jan. 8, 2001

6/10 MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. John N. Mehanna, M.D., 902 Seton Drive, Cumberland, MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 09 2001
32. Registrer's Signature: ▶ Georgia G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 01805

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lawrence George Matt
2. Date of Death Month Day Year: Jan 7, 2001
3. Time of Death: 12:25pm
4a. Facility Name *(If not institution, give street and number)*: Cumberland Nursing Home
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 214-05-5326
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 96 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sep 28, 1904
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street end Number: 6 Broadway Circle
10f. Zip Code: 21502
10g. Citizan of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorcad
12. Was Decadent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Rece - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elamantary/Secondary (0-12): 12 / Collaga (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT usa ratired)*: Clerk
16b. Kind of Business/Industry: Coyle's Market

17. Father's Name *(First, Middle, Last)*: Frank G. Matt
18. Mother'a Name *(First, Middle, Maiden Surnama)*: Agnes (Cosgrove)

19a. Informent's Name/Relationship *(Type, Print)*: Lawrence Davis Nephew
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Coda)*: 44 Blackiston Avenue; Cumberland, MD21502

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Nama of cemetery, crematory or other place)*: St. Mary's Cemetery
Date: 1/09/2001
20c. Location - City or Town, Stete: Cumberland, MD

21. Signature of Funeral Servica Licensee: Nicholas J. Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home P.A. Cumberland, Maryland 21502

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. Coronary Artery Disease — Approximate Interval: 10 years

Due to (or as a consequance of):

Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Wara autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case rafarred to medical examiner? 1 [ ] Yas 2 [X] No

26. Place of Daath *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Panding investigation 6 [ ] Could not be datermined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physicten:** To the best of my knowledge, death occurred at the time, date and placa, and due to tha cause(s) and manner as steted. 2 [ ] **Medical Examtner:** On tha basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: [signature]
29c. License number: D 0033280
29d. Dete signed *(Month, Day, Year)*: Jan 9, 2001

30. Name end addrass of person who completed cause of death (Item 23a) (Type, Print): Sunil K. Gupta M.D. 625 Kent Avenue Cumberland MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01806

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Pauline J. Manlove

2. Date of Death — Month: January Day: 9 Year: 2001

3. Time of Death: 0255

4a. Facility Name (If not institution, give street and number): Union Hospital

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 220-14-1454

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 7-26-1917

9. Birthplace (State or Foreign Country): Delaware

Usual Residence of Decedent

10a. State: Delaware — 10b. County: New Castle — 10c. City, Town or Location: Middletown — 10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5 Berkman Street — 10f. Zip Code: 19709 — 10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Warren Voshell

18. Mother's Name (First, Middle, Maiden Surname): Maude Harvey

19a. Informant's Name/Relationship (Type, Print): Wayne Manlove

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 Berkman Street, Middletown, DE. 19709

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Warwick Cemetery — Date: 1-15-01

20c. Location - City or Town, State: Warwick, Md.

21. Signature of Funeral Service Licensee: Robert [illegible]

22. Name and Address of Facility: DANIELS & HUTCHISON FUNERAL HOME 212 N. Broad st., Middletown, DE. 19709

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Pneumonia — 1wk

Due to (or as a consequence of):
b. CVA — 2mos

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Lung CA

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jose Ma MD

29c. License number: D44716

29d. Date signed (Month, Day, Year): January 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jose Ma, MD 111 W. High St. Elkton, Md.

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001

32. Registrar's Signature: Denise B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01807

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elinor MCLEAN
2. Date of Death Month Jan Day 13 Year 2001
3. Time of Death: 9:50 PM
4a. Facility Name (If not institution, give street and number): SOUTHERN MARYLAND HOSPITAL CENTER
4b. City, Town, or Location of Death: CLINTON
4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 577-01-3054
8. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MARCH 1, 1909
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: CHARLES
10c. City, Town or Location: WALDORF
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 784 UNIVERSITY DRIVE
10f. Zip Code: 20602
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ADMINISTRATIVE ASSISTANT
16b. Kind of Business/Industry: TELEPHONE COMMUNICATIONS (C&P)

17. Father's Name (First, Middle, Last): UNKNOWN
18. Mother's Name (First, Middle, Maiden Surname): UNKNOWN

19a. Informant's Name/Relationship (Type, Print): STEPHEN JOSEPH MCLEAN/SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 784 UNIVERSITY DRIVE, WALDORF, MD 20602

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): RESURRECTION CEMETERY
Date: 1/17/2001
20c. Location - City or Town, State: CLINTON, MARYLAND

21. Signature of Funeral Service Licensee: John P. Knisley JOHN P. KNISLEY M01164
22. Name and Address of Facility: THE HUNTT FUNERAL HOME, INC. WALDORF, MARYLAND 20604-0156

JPK

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Myocardial Infarction

Due to (or as a consequence of): b. Emphysema.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of): c. Possible Carcinoma Lung

Due to (or as a consequence of): d. Chronic Anemia

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Left Fractured Hip on 1-7-01; Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: GR Edelcombe MD
29c. License number: (MD) D23826
29d. Date signed (Month, Day, Year): 1-14-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Glenn Edelcombe, MD 7700 Old Branch Ave Clinton MD

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01808

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen Mitchell

2. Date of Death Month / Day / Year: January 13 2001

3. Time of Death: 4:25PM

4a. Facility Name *(If not institution, give street and number)*: University of Maryland Medical System

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: none

Funeral Director

5. Social Security Number: 212-14-7628

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 5, 1916

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: VA

10b. County: Westmoreland

10c. City, Town or Location: Colonial Beach

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 112 Mimosa Ave.

10f. Zip Code: 22443

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Asst. Manager

16b. Kind of Business/Industry: Dept. Store

17. Father's Name *(First, Middle, Last)*: Bernard Hill

18. Mother's Name *(First, Middle, Maiden Surname)*: Flossie Albert

19a. Informant's Name/Relationship *(Type, Print)*: Judith Ann Johnson

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 16204 Gales St. Laurel, Md. 20707

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mercer Crematory

Date: 1-16-01

20c. Location - City or Town, State: Fredericksburg, Va.

21. Signature of Funeral Service Licensee: E. M. Talbert CC 0395

22. Name and Address of Facility: Nash & Slaw F.H. P.O. Box 366 Ninde, VA. 22526

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier:

29c. License number: U13115

29d. Date signed *(Month, Day, Year)*: January 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lance Uradomo, 22 S Greene St. Baltimore MD 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01809

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANKLIN JAMES NIXON

2. Date of Death: Month January Day 5 Year 2001

3. Time of Death: 1415

4a. Facility Name (If not institution, give street end number): SACRED HEART HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 214-16-2736

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPT. 10, 1915

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: ALLEGANY

10c. City, Town or Location: CUMBERLAND

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 12414 PINE TREE LANE, S.E.

10f. Zip Code: 21502

10g. Citizen of What Country?: U.S.A.

11. Maritel Stetus: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LAYOUT ENGINEER

16b. Kind of Business/Industry: CONSTRUCTION

17. Father's Name (First, Middle, Last): GEORGE MARSHAL NIXON

18. Mother's Neme (First, Middle, Maiden Surneme): ELLAREBECCA ARNOLD

19a. Interment's Name/Relationship (Type, Print): JAMES E. NIXON / SON

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 15301 CRESAP MILL ROAD, SE, OLDTOWN, MD 21555

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removel from Stete 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): DAVIS MEMORIAL CEMETERY

Date: 1/08/2001

20c. Location - City or Town, State: CUMBERLAND, MD

21. Signeture of Funerel Service Licensee: Steven A. Upchurch

22. Name and Address of Facility: UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502

Physician /Medical Examiner

23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart tailure. List only one cause on each line.

Approximate Interval Between Onset and Deeth

Immediate Ceuse (Final disease or condition resulting in death): a. metastatic lung Cacer — 8 months

Due to (or as a consequence of):

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and piece, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: J. Tony Long

29c. License number: D 36766

29d. Date signed (Month, Dey, Year): January 8, 2001

30. Neme and address of person who completed cause ot death (Item 23a) (Type, Print): ViKramaditya Poonal M.D. 924 Seton Drive Cumberland MD 21502

State Registrar

31. Dete filed (Month, Dey, Year): JAN 10 2001

32. Registrar's Signature: Geneva G Lynch

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

8

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01810

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN MARTIN PRICE

2. Date of Death (Month, Day, Year): JANUARY 5,2001

3. Time of Death: 10:20 A.M.

4a. Facility Name (If not institution, give street and number): SACRED HEART HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 218-24-8398

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPT 8,1929

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: LAVALE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 11007 GEORGIA AVE NW

10f. Zip Code: 21502

10g. Citizen of What Country?: USA

11. Meritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American indian, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): BARBER

16b. Kind of Business/Industry: SELF EMPLOYEED

17. Father's Name (First, Middle, Last): HARRY HOMER PRICE

18. Mother's Neme (First, Middle, Maiden Surneme): ELEANOR LUCILLE MARTIN

19a. Informant's Neme/Reletionship (Type, Print): NORMA JEAN PRICE-WIFE

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 11007 GEORGIA AVE NW,LAVALE,MD 21502

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Piece of Disposition (Neme of cemetery, crematory or other place): HILLCREST MEMORIAL PARK Date: JAN 8,2001

20c. Location - City or Town, Stete: CUMBERLAND,MD

21. Signature of Funeral Service Licensee: Douglas S Hafer

22. Name end Address of Feciility: HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY,LAVALE,MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediete Cause (Final disease or condition resulting in deeth): a. cerebrovascular accident — 3 days

Due to (or as e consequenca of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest:

b.

Due to (or as e consequenca of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end manner as stated. 2 [ ] **Medical Examiner**. On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier: J. Toongai

29c. License number: D36766

29d. Date signed (Month, Day, Year): JANUARY 8 ,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Vikramaditya Toongai, M.D. 924 Second Drive Cumberland MD 21502

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001

32. Registrar's Signature: Brenda D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

6

MS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01811

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Hilda Mae Price
2. Dete of Deeth — Month: Jan. Dey: 11 Yeer: 2001
3. Time of Death: 11:45 PM
4a. Facility Neme *(If not institution, give street end number)*: Homestead Manor
4b. City, Town, or Locetion of Deeth: Denton
4c. County of Deeth: Caroline

Funeral Director

5. Sociel Security Number: 215-01-1194
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthdey)*: 94 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 31, 1906
9. Birthplace *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. State: Maryland
10b. County: Talbot
10c. City, Town or Location: Easton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 29291 South Clifton
10f. Zip Code: 21601
10g. Citizen of Whet Country?: United States

11. Merital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* Caucasian

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12): Unknown — College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Home

17. Fether's Neme *(First, Middle, Last)*: Arlington Patton
18. Mother's Neme *(First, Middle, Meiden Surneme)*: Laura Todd

19e. Informent's Name/Reletionship *(Type, Print)*: C. Jane Dieter Stepdaughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: PO Box 577, Denton, Maryland 21629

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Hillcrest Cemetery
Dete: 1/15/01
20c. Location - City or Town, State: Federalsburg, Maryland

21. Signeture of Funeral Service Licensee: Randolph S. Moore
22. Neme end Address of Fecility: Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heert feilure. List *only one* cause on each line.

Approximete Interval Between Onset and Deeth

Immediate Ceuse (Finel disease or condition resulting in deeth)
e. Urosepsis — Approximete Interval: 4 d

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Assisted Living

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Locetion *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the cause(s) end menner es stated.
2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete and piece, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: MD
29c. License number: D0053255
29d. Dete signed *(Month, Dey, Yeer)*: 1/16/01

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Melinda Butler 215 Bloomingdale Ave Federalsburg MD

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 16 20[illegible]
32. Registrer's Signeture: D. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01812

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Elizabeth Genevieve Palmer
2. Date of Death Month / Day / Year: January 16, 2001
3. Time of Death: 0650
4a. Facility Name *(If not institution, give street and number)*: The Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 207-09-9881
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 30, 1919
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Caroline
10c. City, Town or Location: Denton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 320 South Third Street
10f. Zip Code: 21629
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Caucasian

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 6
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher
16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: Harry Franklin Rugh
18. Mother's Name *(First, Middle, Maiden Surname)*: Rachel Agnes Paul

19a. Informant's Name/Relationship *(Type, Print)*: Walter B. Palmer, III Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 121 Butler Drive, Denton, Maryland 21629

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Denton Cemetery
Date: 1/19/01
20c. Location - City or Town, State: Denton, Maryland

21. Signature of Funeral Service Licensee: Randolph P. Moore
22. Name and Address of Facility: Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	4 days
Due to (or as a consequence of):	b. Acute Renal failure	4 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Dehydration	4 days
Due to (or as a consequence of):	d. Hyponatremia	4 days

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Myocardial Infarction

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: James F. Elmore State Physician
29c. License number: D50328
29d. Date signed *(Month, Day, Year)*: 1/16/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James F. Elmore, M.D., c/o Memorial Hospital, 219 South Washington St., Easton, Maryland 21601

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 18 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Genevieve Palmer

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01813

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marjorie Phillips
2. Date of Death (Month, Day, Year): January 11, 2001
3. Time of Death: 9:45 A.M.
4a. Facility Name (If not institution, give street and number): Calvert Manor Healthcare Center
4b. City, Town, or Location of Death: Rising Sun
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 221-14-0069
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): November 21, 1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Delaware
10b. County: New Castle
10c. City, Town or Location: Wilmington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2300 Riddle Ave. Apt. #107
10f. Zip Code: 19801
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indian, Black, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: DuPont Company

17. Father's Name (First, Middle, Last): Edward Phillips
18. Mother's Name (First, Middle, Maiden Surneme): Bertha Dunbar

19a. Informant's Name/Relationship (Type, Print): Amy R. Dunbar-Cousin
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 215 Charleston Greene Malvern, Pa. 19355

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Elkton Cemetery | Date: 1/19/01
20c. Location - City or Town, State: Elkton, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Gee Funeral Home 259 E. Main St. Elkton, Md. 21921

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on each line.

Approximete Interval Between Onset and Deeth

Immediate Cause (Finel disease or condition resulting in death)
a. End Stage COPD — Approximate Interval: years
Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest
b. Due to (or as e consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Pulmonary Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medicel exeminer? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2☐ **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D45155
29d. Date signed (Month, Day, Year): 1/11/01
30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): JOHN MULVEY 111 W. HIGH ST. ELKTON, MD. 21921

25

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01814

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Betty Mae Ralston
2. Date of Death Month Day Year: Jan 2, 2001
3. Time of Death: 11:10pm
4a. Facility Name *(If not institution, give street and number)*: 225 Pennsylvania Avenue
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 213-24-7014
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jun 9, 1928
9. Birthplace *(State or Foreign Country)*: WV

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 225 Pennsylvania Avenue
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decadant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elemantery/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner/Operator
16b. Kind of Business/Industry: South End Antiques

17. Fathar's Name *(First, Middle, Last)*: Perry Kerns
18. Mother's Nama *(First, Middle, Maiden Surname)*: Deanie (Whetzel)

19a. Informant's Name/Relationship *(Type, Print)*: Glendon A. Ralston husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 2092;Cumberland, MD21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetary, crametory or other piece)*: Rocky Gap Veterans Cem
Data: 1/05/2001
20c. Location - City or Town, State: Flintstone, MD
21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home P.A. Cumberland, Maryland 21502

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that caused the death. Do not antar tha mode ot dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximata Intarval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction

Due to (or as a consequence ot):

Sequentially list conditions, if any, leading to immediete cause. Entar Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last
b. Advanced Gastric Carcinoma

Due to (or as a consequence ot):
c.

Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, tarm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at the time, data and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D23371
29d. Data signed *(Month, Day, Year)*: Jan 9, 2001

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print): Qamar U Zaman M.D. 625 Kent Avenue Cumberland MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 09 2001
32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

5

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01815

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILLIAM C REID JR.

2. Date of Death: Month 01 Day 02 Year 2001

3. Time of Death: 9:40 PM

4a. Facility Name *(If not institution, give street and number)*: 708 BROADCREEK DRIVE

4b. City, Town, or Location of Death: STEVENSVILLE

4c. County of Death: QUEEN ANNE'S

Funeral Director

5. Social Security Number: 195-28-3696

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 11/10/1937

9. Birthplace *(State or Foreign Country)*: PENNSYLVANIA

Usual Residence of Decedent

10a. State: MD

10b. County: QUEEN ANNE'S

10c. City, Town or Location: STEVENSVILLE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 708 BROADCREEK DRIVE

10f. Zip Code: 21666

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MEAT CUTTER

16b. Kind of Business/Industry: RETAIL MARKETS

17. Father's Name *(First, Middle, Last)*: WILLIAM C. REID

18. Mother's Name *(First, Middle, Maiden Surname)*: ELIZABETH KIRCHNER

19a. Informant's Name/Relationship *(Type, Print)*: JANICE C. REID / WIFE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1009 KEYSTONE DR. LANCASTER, PA 17603

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ST. JOSEPH NEW CATHOLIC CEM | Date: 1/5/01

20c. Location - City or Town, State: LANCASTER, PA

21. Signature of Funeral Service Licensee: Chad M. Hebb

22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 106 SHAMROCK ROAD CHESTER, MD 21619

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Heart Disease	IMMEDIATE
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dyslipidemia
Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D0005754

29d. Date signed *(Month, Day, Year)*: 01-03-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RALPH LIBBY MD 204 MEDICAL CENTER ROAD GRASONVILLE, MD 21638

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 2001

32. Registrar's Signature: Geneva G. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01816

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Emma C. Rinker
2. Data of Death Month Day Yaar: Jan 6, 2001
3. Time of Death: 05:30am
4a. Facility Name *(If not institution, give street and number)*: Devlin Manor Nursing Home
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 214-07-3748
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 93 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Sep 13, 1907
9. Birthplace *(State or Foreign Country)*: WV

Usual Residence of Dacedant

10a. Stata: MD
10b. County: Allegany
10c. City, Town or Location: Oldtown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 21803 Monte Notte Terrace SE
10f. Zip Coda: 21555
10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Never Marriad 2☐ Married ☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yas ☒ No If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 1☐ Yes 2☒ No *Specify:*
14. Race - Amarican Indian, Black, Whita, atc. *Specify:* white

15. Dacedant's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / Collega (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Businass/Industry: Own Home

17. Fathar's Nama *(First, Middle, Last)*: A.W. Smith
18. Mothar's Nama *(First, Middle, Maiden Sumame)*: Anna (Brown)

19a. Informant's Name/Ralationship *(Type, Print)*: Robert R. Rinker SON
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 1283;Bunnell, FL32110

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donetion 5☐ Othar *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Sunset Memorial Park
Data: 1/09/
20c. Location - City or Town, Stata: 2001 Cumberland, MD

21. Signature of Funaral Service Licansee: Nicholas J. Scarpelli
22. Nama and Address of Facility: Scarpelli Funeral Home P.A. Cumberland, Maryland 21502

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused the daath. Do not antar the moda of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximata Intarval Batween Onset and Death

Immediata Causa (Final disaasa or condition resulting in deeth)
a. Coronary artery disease — 10 years
Due to (or as a consequance of):
b.
Dua to (or as a consequance of):
Sequantially list conditions, if any, laeding to Immadiata cause. Enter Underlying Causa (Disaasa or Injury that initiated avants raaulting in daeth) Last
c.
Dua to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.
Dementia
Seizure disorder

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☒ No
24b. Wera autopsy findings availabla prior to completion of cause of death? 1☐ Yas 2☐ No

25. Wes case refarred to medical examinar? 1☐ Yaa 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA Other: 4☒ Nursing Homa 5☐ Rasidance 8☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be datarmined
28a. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Date of Injury *(Month, Day Year)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledge, death occurred at the time, date and place, end dua to tha causa(s) and manner as stated. 2☐ **Medical Examiner:** On the basia of examination and/or investigation, in my opinion, death occurred at tha tima, date and place, and due to the ceuse(s) and manner stated.

29b. Signatura and title of certifiar: [signature]
29c. License number: D0033280
29d. Data signed *(Month, Day, Year)*: Jan 8, 2001

30. Nama and addrass of person who completed ceuse of death (Item 23a) (Type, Print): Sunil K. Gupta M.D. 625 Kent Avenue Cumberland MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 09 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with tha Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requires that tha death certificate be executed within 24 hours after daath.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by tha funaral director, page 2 should be detached for usa as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01817

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILLIAM FRANKLIN ROBERTSON SR.

2. Date of Death Month Day Yaar: JANUARY 11 2001

3. Time of Death: 18:20PM

4a. Facility Name *(If not institution, giva street end number)*: ALLEGANY CO. NURSING HOME

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 214-05-9047

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 105 Yrs.

If Under 1 Yaer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: JUNE 20 1895

9. Birthplace *(State or Foreign Country)*: W.VA.

Usuel Residence of Decedant

10a. Stata: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: CUMBERLAND

10d. Insida City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: FURNACE STREET EXT.

10f. Zip Coda: 21502

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1 [ ] Navar Marriad 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 [ ] Yas 2 [X] No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* WHITE

15. Decedent's Educetion *(Specify only highast grada completad)*: Elementery/Secondary (0-12): 5 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa ratired)*: B&O RAILROAD

16b. Kind of Businass/Industry: RAILROAD

17. Fathar's Nama *(First, Middla, Last)*: BENJAMIN F. ROBERTSON

18. Mothar's Nema *(First, Middla, Maiden Sumema)*: EMMALINE McCULLEY

19a. Informant's Name/Ralationship *(Type, Print)*: WILLIAM F. ROBERTSON JR. SON

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 516 RHODE ISLAND AVE HAGERTSOWN, MARYLAND 21740

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*

20b. Place of Disposition *(Neme of cemafary, crematory or othar place)*: SUNSET CEMETERY Date: JAN 15 2001

20c. Location - City or Town, Stata: CUMBERLAND MARYLAND

21. Signatura of Funeral Service Licensee: Dale L. Merritt

22. Nama and Address of Facility: MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part1. Entar the disaasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediate Causa (Final disaasa or condition resulting in daath) a.	CONGESTIVE HEART FAILURE	5 YRS
Dua to (or as a consequence of):		
Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying Causa (Diseesa or injury that initiated avants resulting in deeth) Lest b.	ARTERIOSCLEROTIC HEART DISEASE	5 YRS
Dua to (or as e consequance of):		
c.		
Due to (or es e consequence of):		
d.		

Part II. **Othar significant conditions** contributing to daath but not rasulting in the undariying cause given in Part I.: CHRONIC OBSTRUCTIVE PULMONARY DISEASE; CARCINOMA OF THE PROSTATE

23b. Did tobacco usa contributa to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Were autopsy findings available prior to complation of cause of death? 1 [ ] Yas 2 [X] No

25. Was cesa rafarrad to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Daath *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Othar: 4 [X] Nursing Hema 5 [ ] Rasidance 6 [ ] Othar *(Specify)*

27. Mannar of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding Invastigation 6 [ ] Could not be determined

28a. Deta of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, ferm, streat, factory, office building, etc. *(Specify)*

28f. Location *(Streat and Number or Rural Routa Number, City or Town, Stata)*

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and piece, and dua to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daeth occurred at the time, dete and piece, and due to the causa(s) and manner stated.

29b. Signeture and titla of certifier: Robustiano J. Barrera, Jr.

29c. Licansa number: D-14865

29d. Date signad *(Month, Day, Year)*: JAN. 14, 2001

30. Nama and address of parson who completed causa of daath (Item 23a) (Type/Print): ROBUSTIANO J. BARRERA JR. MD. CUMBERLAND, MD. 21502

State Registrar

31. Deta filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signatura: Brenda G Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

2

MD

01-0026-001
CJ
Crystal Cora Rounds

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01818

AMENDED ITEMS #28a-f per ME-G792 030101 SS

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner — **Funeral Director** — **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): CRYSTAL CORA ROUNDS
2. Date of Death: Month January Day 01 Year 2001
3. Time of Death: 11:45 A.M.
4a. Facility Name (If not institution, give street and number): 17012 McMullen Highway # 29
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany
5. Social Security Number: 265-63-1292
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 40 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 24, 1960
9. Birthplace (State or Foreign Country): Japan

Usual Residence of Decedent

10a. State: WV
10b. County: Mineral
10c. City, Town or Location: Keyser
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 172 "B" Street
10f. Zip Code: 26726
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1978-79
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Registered Nurse
16b. Kind of Business/Industry: Hospital Nursing

17. Father's Name (First, Middle, Last): John Terwilliger
18. Mother's Name (First, Middle, Maiden Surname): Ruth Shelcross

19a. Informant's Name/Relationship (Type, Print): Robert W. Rounds/ Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 172 "B" Street Keyser, WV 26726

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): The Cumberland Crematory
Date: Jan. 6 2001
20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: ▶ Brian L. Smith
22. Name and Address of Facility: Smith Funeral Home 85 S. Main Street Keyser, WV 26726

Physician /Medical Examiner — **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Asphyxia
Due to (or as a consequence of):
b. Placement of Plastic Bag over head with
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. a mixed drug intoxication
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) XX Scene

27. Manner of Death: 1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year) found: 1-1-01
28b. Time of Injury found: 11:45 A M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: subject took drugs and placed plastic bag over her head
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): found in motel
28f. Location (Street and Number or Rural Route Number, City or Town, State) 17012 McMullen Hgwy# 29 Cumberland, MD

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Dennis Chute MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): January 2, 2001

10
Per Georgia Price
TBS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chute MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: ▶ Gena B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01819

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary L. Rummer

2. Date of Death: Month 01 Day 12 Year 2001

3. Time of Death: 5:59 PM

4a. Facility Name (If not institution, give street and number): Memorial Hospital & Medical Center

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 215-16-4787

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jul 19, 1911

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 719 Sylvan Avenue

10f. Zip Code: 21502

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highast grada complatad): Elamantary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired): waitress

16b. Kind of Businass/Industry: restaurant

17. Father's Name (First, Middla, Last): Edwin Jones

18. Mother's Name (First, Middla, Maiden Sumama): Bertha F (Brooks)

19a. Intormant's Name/Relationship (Type, Print): Esther Lorraine Rummer Daughter-in-law

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 717 Sylvan Avenue;Cumberland MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Nama of camatary, cramatory or othar place): Davis Memorial Cemeter

Date: 1/16/2001

20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funaral Service Licensee: ▶ James J Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only one cause on each line.

Approximata Interval Between Onset and Death

Immediata Causa (Final disease or condition resulting in death)

a. Bilateral pneumonia — 10 days

Due to (or as a consequence of):

Sequentially list conditions, if sny, laading to immediate ceuse. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last

b.

Due to (or as a consequance of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa rafarred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only ona): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, street, tactory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to tha cause(s) and mannar as stated. 2☐ **Medical Examiner**: On the basis ot examination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier: ▶

29c. License number: D0033280

29d. Date signed (Month, Day, Year): JANUARY 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GUPTA, SUNIL K., M.D., 625 KENT AVENUE, SUITE 101, CUMBERLAND, MD 21502

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: B Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

MARY LOUISE RUMMER 215-16-4787

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

MLS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 01820

NAME KNOWN TO PHYSICIAN: RAGAN, EARL N. JR.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Earl N. Ragan, Jr.

2. Dete of Deeth: Month JANUARY Day 12 Yeer 2001

3. Time of Death: 5:30AM

4a. Facility Neme (If not institution, give street and number): VA MARYLAND HEALTH CARE SYSTEM

4b. City, Town, or Location of Death: PERRY POINT

4c. County of Deeth: CECIL

Funeral Director

5. Sociel Security Number: 218-07-8957

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): Oct. 22, 1920

9. Birthplace (Stete or Foreign Country): Pennsylvania

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Cecil

10c. City, Town or Location: Conowingo

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 495 Conowingo Road

10f. Zip Code: 21918

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes: WW II

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - Americen Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Construction

17. Father's Neme (First, Middle, Last): Earl N. Ragan

18. Mother's Neme (First, Middle, Meiden Surname): Mary Rando

19e. Informent's Neme/Reletionship (Type, Print): Doris E. Ragan/Wife

19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 495 Conowingo Road, Conowingo, MD 21918

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Conowingo Baptist Cemetery

Date: 1-16-01

20c. Location - City or Town, State: Conowingo, Maryland

21. Signeture of Funerel Service Licensee: Richard L. Goodie

22. Neme and Address of Fecility: R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA — UNKNOWN

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

CEREBROVASCULAR ACCIDENT

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end manner es stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end manner stated.

29b. Signeture end title of certifier: Samir Kheiri MD

29c. License number: D0052064

29d. Dete signed (Month, Dey, Yeer): JANUARY 12, 2001

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): SAMIR KHEIRI, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 12 2001

32. Registrer's Signeture: Brenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01821

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Corinne Rosebrook

2. Date of Death (Month, Day, Year): January 11, 2001

3. Time of Death: 9:45 A.M.

4a. Facility Name (If not institution, give street and number): Manor Care Chevy Chase

4b. City, Town, or Location of Death: Chevy Chase

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 006-30-7843

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 107 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 10, 1893

9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State | 10b. County | 10c. City, Town or Location: Washington, D.C. | 10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2700 Wisconsin Avenue N.W. Apt. 810

10f. Zip Code: 20007

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Charles John Rosebrook

18. Mother's Name (First, Middle, Maiden Surname): Frances Baker

19a. Interment's Name/Reletionship (Type, Print): Robert Tomlinson/ Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4400 East-West Highway, Bethesda, MD 20014

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Geo. Wash. University Medical Center | Date: January 11 20001

20c. Location - City or Town, State: Washington, ,D.C.

21. Signature of Funeral Service Licensee: Arthur C. Woods

22. Name and Address of Facility: Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C. 20037

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. OLD AGE — YRS

Due to (or as a consequence of):

b. ALZHEIMERS DEMENTIA — 10 YRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

BREAST CANCER

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Peter Hamm

29c. License number: D32033

29d. Date signed (Month, Day, Year): 1/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PETER HAMM, M.D. 5454 WISC AVE CHEVY CHASE MD 20815

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001

32. Registrar's Signature: Jeanne D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01822

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Frances Satterfield
2. Date of Death Month Day Year: January 14, 2001
3. Time of Death: 9:53 PM
4a. Facility Name *(If not institution, give street and number)*: 108 Granby Street
4b. City, Town, or Location of Death: Greensboro
4c. County of Death: Caroline

Funeral Director

5. Social Security Number: 215-38-1807
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 60 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 8, 1940
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Caroline
10c. City, Town or Location: Greensboro
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 108 Granby Street
10f. Zip Code: 21639
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: housewife
16b. Kind of Business/Industry: own home

17. Father's Name *(First, Middle, Last)*: Charles Jack Walls
18. Mother's Name *(First, Middle, Maiden Surname)*: Ethel Mae Kemp

19a. Informant's Name/Relationship *(Type, Print)*: John H Satterfield Sr spouse
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 108 Granby Street Greensboro, Maryland 21639

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Greensboro Cemetery — Date: Jan 18 2001
20c. Location - City or Town, State: Greensboro, Maryland

21. Signature of Funeral Service Licensee: Steven C Fleegle
22. Name and Address of Facility: Fleegle - Helfenbein Funeral Home PA PO Box 160 Greensboro, Maryland 21639

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. — Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC LUNG CARCINOMA — 1 MONTH
Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last
b.
Due to (or es a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
RHEUMATIC HEART DISEASE
CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the ceuse of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medicel examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: W Brem MD
29c. License number: D26350
29d. Date signed *(Month, Day, Year)*: 1/18/2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): WILLIAM S. BREMER, MD 800 S. TALBOT ST., ST. MICHAELS, MD 21663

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 18 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01823

Clarence Stull

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

1. Decedent's Nsme *(First, Middle, Last)*: Clarence C. Stull
2. Dete of Death (Month, Dsy, Yesr): January 14 2001
3. Time of Death: 0012
4e. Facility Neme *(If not institution, give street end number)*: The Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Deeth: Talbot
5. Sociel Security Number: 191-10-5376
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthdey)*: 84 Yrs. | If Under 1 Yeer: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: Jun.17,1916
9. Birthpiece *(Stete or Foreign Country)*: Pennsylvania

Usuel Residence of Decedent

10a. Stete: MD
10b. County: Caroline
10c. City, Town or Location: Federalsburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street snd Number: 309 Maple Avenue
10f. Zip Code: 21632
10g. Citizen of What Country?: United States

11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Dates: '44-46
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Reca - American Indian, Bieck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuei Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Town Manager
16b. Kind of Business/Industry: Municipal Gov't.

17. Father's Neme *(First, Middle, Last)*: Sanford F. Stull
18. Mother's Neme *(First, Middle, Meiden Surneme)*: Minnie Maude Wolfe

19a. Informant's Name/Reletionship *(Type, Print)*: Jean E. Stull/Spouse
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 309 Maple Ave., Federalsburg, MD 21632

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other pleca)*: Eastern Shore Vet.
Dete: 1/17/01
20c. Location - City or Town, Stete: Hurlock, MD

21. Signeture of Funerei Service Licensee: ▶ Michael T. Eskow
22. Neme end Address of Feciility: Framptom-Hawkins-Eskow Funeral Home PO Box 43, Federalsburg, MD 21632

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heert feilure. List only one cause on eech line. — Approximate Intervel Between Onset end Deeth

Immediate Cause (Finel disease or condition resulting in deeth)
a. renal failure — week
Due to (or es a consequenca of):
b. hypotension — day
Due to (or es e consequenca of):
c. pneumonia — days
Due fo (or es e consequence of):
d.

Sequentially list conditions, if sny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

pancreatic mass

chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24e. Wes an eutopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Deeth *(Check only one)*: Hospitel: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Menner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, streef, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end menner steted.

29b. Signeture end titie of certifier: ▶ Kathleen Hoey
29c. License number: D47627
29d. Date signed *(Month, Dey, Yeer)*: 1-14-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kathleen Hoey, M.D., 2540 Centreville Rd, Centreville, MD 21617

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 17 2001
32. Registrer's Signature: ▶ Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01824

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: NANCY M. SCHULZ

2. Deta of Death Month Day Yaer: January 8, 2001

3. Tima of Death: 6:54am

4a. Facility Neme *(If not institution, giva streat end number)*: Union Hospital

4b. City, Town, or Location of Deth: Elkton

4c. County of Death: Cecil

Funeral Director

5. Sociel Sacurity Numbar: 162-30-1983

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. lest birthdey)*: 70 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec 23 1930

9. Birthplaca *(Stete or Foraign Country)*: Pennsylvania

Usuel Residence of Decedent

10e. State: MD

10b. County: Cecil

10c. City, Town or Location: Cecilton

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 172 Center St. Apt. 4-B

10f. Zip Code: 21913

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☒ Navar Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedant Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Amarican Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elamantary/Secondary (0-12): 8 | Collega (1-4or 5+):

16e. Decedent's Usual Occupetion *(Give kind of work dona during most of working life. DO NOT use ratired)*: never worked

16b. Kind of Businass/Industry: disabled

17. Fether's Neme *(First, Middle, Lest)*: Frederick Schulz

18. Mother's Neme *(First, Middle, Malden Surname)*: Marie Johnston

19e. Informant's Neme/Raletionship *(Type, Print)*: Steven W. Miller (nephew)

19b. Mailing Address *(Streat and Number or Rurel Route Number, City or Town, State, Zip Coda)*: 7 Sherring Way Tabernacle, NJ. 08088

20e. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetary, cremetory or other piece)*: Glenwood Mem Gardens

Dete: 1/11/01

20c. Location - City or Town, State: Broomall, PA.

21. Signature of Funeral Service Licensee: M00510

22. Name end Address of Facility: Galena Funeral Home of Stephen Schaech 118 West Cross St. Galena, MD. 21635

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or hart failure. List only one ceusa on aach line.

Approximete Intervel Batween Onset and Deeth

Immedieta Cause (Finel disease or condition resulting in deeth)

a. sepsis — 6 days

Dua to (or es e consequanca of):

b. perforated pre-pyloric ulcer

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disaesa or Injury thet Initiatad avants resulting in deeth) Last

Due to (or as e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying ceuse givan in Part I.

metastatic adeno carcinoma breast cancer

23b. **Did tobacco uee contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Ware eutopsy findings available prior to complation of ceuse of death? 1☐ Yas 2☒ No

25. Was cese refarrad to medicel examiner? 1☐ Yes 2☒ No

28. Place of Deeth *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Streat end Number or Rural Route Number, City or Town, State)*

29e. Certifiar *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowladga, death occurred et the time, data end plece, end dua to tha cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of axamination end/or investigation, in my opinion, daath occurred at tha time, data end placa, and due to the ceuse(s) end mannar stated.

29b. Signetura and title of certifier: W. Obenshain, MD

29c. License number: 0 0035779

29d. Dete signed *(Month, Dey, Year)*: January 8, 2001

30. Nama end eddrass of person who completed ceusa of daath (item 23e) (Type, Print): W. Bruce Obenshain, MD 251 S. Bohemia Ave. Cecilton, MD. 21913

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 10 2001

32. Registrer's Signature: Brenda D. Sparks

DHMH 16 Rev 6/95

Funeral Director: To Be Completed by Funeral Director

Physician /Medical Examiner: Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Haalth and Mantel Hygiena.

Important: If item 27 is marked other than 'natural', or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requiras that tha death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01825

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Josephine Skozypic
2. Date of Death (Month, Day, Year): January 10, 2001
3. Time of Death: 1:00A.M.

4a. Facility Name (If not institution, give street and number): Calvert Manor Healthcare Center
4b. City, Town, or Location of Death: Rising Sun
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 215-32-7407
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 17,1909
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Elkton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 150 E. Main St.
10f. Zip Code: 21921
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5 | College (1-4or 5+): –
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assembly Department
16b. Kind of Business/Industry: R.M.R. Corporation

17. Father's Name (First, Middle, Last): Adam Schrajber
18. Mother's Name (First, Middle, Maiden Surname): Catherine Litwa

19a. Informant's Name/Relationship (Type, Print): Eleanor Fritz-Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 175 Childs,Md. 21916

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Immac.Conception Cem. Date: 1/13/01
20c. Location - City or Town, State: Cherry Hill,MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Gee Funeral Home 259 E. Main St. Elkton, Md. 21921

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Colon cancer
Due to (or as a consequence of):
b. cerebrovascular accident
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Anemia
Angina
Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D46412
29d. Date signed (Month, Day, Year): 1/10/2001
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Physicians 319 S. Union Ave Hdc MD 21078
31. Date filed (Month, Day, Year): JAN 12 2001
32. Registrar's Signature: [signature]

State Registrar

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01826

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Elizabeth C. Smith
2. Date of Death Month / Dey / Yeer: January 13, 2001
3. Time of Deeth: 11:00 am
4e. Feciiity Neme *(If not institution, give street and number)*: Calvert Manor Healthcare Center
4b. City, Town, or Location of Deeth: Rising Sun
4c. County of Death: Cecil

Funeral Director

5. Sociel Security Number: 458-34-0796
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. lest birthdey)*: 75 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: Aug. 3, 1925
9. Birthpiece *(State or Foreign Country)*: Texas

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Cecil
10c. City, Town or Location: Elkton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 72 Crestwood Dr.
10f. Zip Code: 21921
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* White
15. Decedent's Educetion *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home
17. Fether's Neme *(First, Middle, Last)*: Charles S. Cowell
18. Mother's Neme *(First, Middle, Meiden Surneme)*: Bessie Hamilton
19a. Informent's Neme/Reletionship *(Type, Print)*: David W. Smith/Son
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 72 Crestwood Dr., Elkton, MD 21921
20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, crematory or other piece)*: Lower Brandywine Cemetery
Dete: 1-17-01
20c. Location - City or Town, State: Wilmington, Delaware
21. Signature of Funerel Service Licensee: ▶ [signature]
22. Name and Address of Facility: R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heart feilure. List only one cause on eech line.

Immediete Ceuse (Finel diseese or condition resulting in deeth)
e. Cerebro vascular Accident — Approximete Interval Between Onset end Death: 4 days
Due to (or es e consequence of):
b. A.S.C.V.D. — 2 yrs
Sequentielly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: none

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveileble prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*:
28b. Time of Injury: M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred:
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*:
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*:

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyaician**: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end manner es stated. 2☐ **Medical Examiner**: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end menner steted.

29b. Signature and title of certifier: ▶ Neil Taylor MD
29c. License number: D-11115
29d. Date signed *(Month, Dey, Yeer)*: Jan. 13, 01

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Neil Taylor MD, Calvert Health Car Center Rising Sun MD 21911

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 16 2001
32. Registrer's Signeture: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

VD

15

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01827

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Sadie Elane Turner

2. Date of Death (Month, Day, Year): January 13, 2001

3. Time of Death: 1625

4a. Facility Name *(If not institution, give street and number)*: Sacred Heart Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 213-24-6739

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 06-Jul-28

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Allegany

10c. City, Town or Location: Frostburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 100 Honeysuckle Lane Apt. 204

10f. Zip Code: 21532-

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk

16b. Kind of Business/Industry: Department Store

17. Father's Name *(First, Middle, Last)*: Weaver Turner

18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret H. Pyle

19a. Informant's Name/Relationship *(Type, Print)*: Cheryl Turner niece

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1114 Circle Drive Martinsburg West Virginia 25401-

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cumberland Crematory

Date: 14-Jan-01

20c. Location - City or Town, State: Cumberland, Maryland

21. Signature of Funeral Service Licensee: ▶ Gary L. Durst

22. Name and Address of Facility: Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure — 2 Days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. COPD Exacerbation — 5 days

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Wonsock Shin MD.

29c. License number: D0055325

29d. Date signed *(Month, Day, Year)*: January 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WONSOCK SHIN MD 48 Tarn Terrace Frostburg, MD 21532.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: ▶ Georgia D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

6

JMS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01828

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frederick Robert Thompson
2. Date of Death (Month, Day, Year): Jan. 10 2001
3. Time of Death: 7:26 pm
4a. Facility Name (If not institution, give street and number): Dorchester General Hospital
4b. City, Town, or Location of Death: Cambridge
4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 219-32-8231
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 16 1934
9. Birthplace (State or Foreign Country): Maryland

Usual Residance of Decedent

10a. State: MD
10b. County: Dorchester
10c. City, Town or Location: Galestown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10a. Street and Number: 5543 Galestown Road
10f. Zip Code: 19973
10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1 [ ] Navar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 [ ] Yas 2 [X] No If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:
14. Race - American Indian, Black, Whita, atc. Specify: white

15. Decedent's Education (Specify only highast grada compiatad): Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): plumber
16b. Kind of Business/Industry: construction

17. Fathar's Nama (First, Middla, Last): Shelton E. Thompson
18. Mothar's Nama (First, Middla, Maidan Surnama): Nettie Walker

19a. Informant's Name/Relationship (Type, Print): Dorothy J. Thompson - wife
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 5543 Galestown Rd., Seaford, DE 19973

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar (Specify)
20b. Place of Disposition (Nama of cematary, crematory or othar piaca): East New Market cemetery
Data: 1-13
20c. Location - City or Town, Stata: East New Market, MD

21. Signature of Funaral Service Licensee: ▶ [signature]
22. Nama and Addrass of Facility: Thomas Funeral Home PA 700 Locust St., Cambridge, MD 21613

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina. — Approximata Intarval Between Onset and Death

Immediata Causa (Final disaasa or condition rasulting in death): a. Coronary Artery Disease
Dua to (or as a consequence of):
Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury that initiatad avants rasulting in death) Last:
b. Dua to (or as a consequance of):
c. Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa givan in Part I.: Hypertension; Diabetes

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No
24b. Wara autopsy findings available prior to compiation of cause of death? 1 [ ] Yas 2 [X] No

25. Was casa rafarrad to medical examinar? 1 [ ] Yas 2 [X] No
26. Placa of Death (Check only ona): Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatiant 3 [X] DOA | Othar: 4 [ ] Nursing Homa 5 [ ] Rasidance 6 [ ] Othar (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding Investigation 6 [ ] Could not be datarmined
28a. Data of Injury (Month, Day Yaar)
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Dascribe how injury occurred
28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifiar (Check only one): 1 [X] **Certifying Physician:** To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signatura and titla of certifiar: ▶ Timothy J. Sniezek
29c. Licansa number: D53253
29d. Data signad (Month, Day, Yaar): 1/10/2001

30. Nama and addrass of parson who completad causa of daath (item 23a) (Type, Print): Timothy J. Sniezek MD 503-A MUIR ST CAMBRIDGE, MD 21613

State Registrar

31. Data filad (Month, Day, Yaar): JAN 12 2001
32. Registrar's Signatura: Renee G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01829

Physician /Medical Examiner

1. Decadant's Nama (First, Middla, Last): Velma Mac Worgan
2. Data of Daath — Month: January Day: 10, 2001 Yaar:
3. Tima of Daath: 5:00 A.M.

4a. Facility Nama (If not institution, giva street and numbar): Egle Nursing Home
4b. City, Town, or Location of Daath: Lonaconing
4c. County of Daath: Allegany

Funeral Director

5. Social Security Numbar: 214-07-3972
6. Sax: 1☐ M 2☒ F
7. Aga (In yrs. last birthday): 86 Yrs. — If Under 1 Yaar: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Yaar): June 28, 1914
9. Birthplaca (Stata or Foreign Country): Maryland

Usual Rasidance of Decadant

10a. Stata: Maryland
10b. County: Allegany
10c. City, Town or Location: Lonaconing
10d. Insida City Limits: 1☒ Yes 2☐ No
10e. Straat and Numbar: 57 Jackson Street
10f. Zip Coda: 21539
10g. Citizan of What Country?: USA

11. Maritel Statua: 1☐ Navar Marriad 2☐ Marriad 3☒ Widowad 4☐ Divorcad
12. Was Decedant Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No Specify:
14. Race - Amarican Indian, Black, Whita, atc. Specify: White

15. Dacedent's Education (Spacify only highast grada compiatad): Elementary/Secondary (0-12): 11 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Textile
16b. Kind of Businass/Industry: Labor

17. Fathar's Nama (First, Middla, Last): Samuel McCutcheon
18. Mothar's Nama (First, Middla, Maidan Surnama): Elizabeth Fairgrieve

19a. Informant's Name/Ralationship (Type, Print): Ruth H. Nicol-sister
19b. Mailing Addrass (Street and Numbar or Rural Route Numbar, City or Town, Stata, Zip Coda): 16014 Upper Rockville Street S.W.,Lonaconing,Md. 21539

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Nama of cematary, crematory or othar placa): Hillcrest Burial Park
Data: January 12, 2001
20c. Location - City or Town, Stata: Cumberland,Md.

21. Signature of Funaral Service Licensee: ▶ James E. McKenzie
22. Nama and Addrass of Facility: Eichhorn-McKenzie Funeral Home P.A. 8 E. Main St.,Lonaconing,Md.21539

Physician /Medical Examiner

23a. Part I. Enter tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or hoart failura. List only ona causa on aach lina.

Approximate Intarval Batwaan Onsat and Death

Immadiata Causa (Final disaasa or condition resulting in daath)
e. Cerebral Vascular Accident — 1 mo.
Dua to (or as a consaquanca of):
Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or injury that initiatad avants rasulting in daath) Last
b. Generalized Atherosclerosis — 5 years
Dua to (or as a consaquanca of):
c.
Dua to (or as a consaquanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.
Dementia, Alzheimer's Type - advanced

23b. Did tobacco use contribute to the causes of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA — Othar: 4☒ Nursing Homa 5☐ Residence 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determinad
28a. Data of Injury (Month, Day Yaar)
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify)
28f. Location (Street and Numbar or Rural Route Numbar, City or Town, Stata)

29a. Cartifier (Check only one): 1☒ **Certifying Physician:** To the bast of my knowladga, death occurred at tha tima, data and placa, and due to the ceuse(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, data and placa, and due to tha causa(s) and mannar stated.

29b. Signature and title of certifier: ▶ L Miles Jr. MD.
29c. License number: D07004
29d. Data signed (Month, Day, Yaar): Jan. 10, 2001

30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print): L. R. MILES, JR. M.D. 57 JACKSON ST, LONACONING, MD. 21539

State Registrar

31. Data filed (Month, Day, Yaar): JAN 10 2001
32. Registrar's Signatura: Barbara G Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

MLS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01830

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Wilhelmina Warnick

2. Date of Death Month Day Year: January 13, 2001

3. Time of Death: 2:38 am

4e. Facility Name (If not institution, give street and number): Memorial Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 217-18-4721

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): December 05, 1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Allegany

10c. City, Town or Location: Nikep

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 17655 Lower Georges Creek Rd

10f. Zip Code: 21546

10g. Citizen of What Country?: USA

11. Meritel Status: 1☐ Never Merried · 2☐ Merried 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Neme (First, Middle, Last): Albert Lee

18. Mother's Name (First, Middle, Maiden Surname): Edna Pearl Thomas

19a. Informant's Name/Relationship (Type, Print): Gregory L. Warnick-son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10514 Mt. Savage Rd. N.W.,Cumberland,Md. 21502

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Laurel Hill Cemetery

Date: January 16, 2001

20c. Location - City or Town, Stete: Moscow Mills,Md.

21. Signeture of Funerel Service Licensee: Ann E. McKenzie

22. Neme end Address of Facility: Eichhorn-McKenzie Funeral Home P.A.,Lonaconing,Md. 21539

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feilure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in deeth)

a. Septic shock — 2 weeks

Due to (or es a consequence of):

b. Ischemic colon — 1 year

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Pert tt. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signeture and title of certifier: Terry Williams MD

29c. License number: D16041

29d. Dete signed (Month, Day, Year): January 14, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Terry Williams, Memorial Hospital Medical Bldg., Cumberland, MD 21502

State Registrar

31. Dete filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signetura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

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MD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01831

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROBERT LEE WAGNER
2. Data of Deeth — Month: January Day: 8 Year: 2001
3. Tima of Death: 9:30 AM
4a. Facility Neme *(If not Institution, giva street and number)*: Sacred Heart Hospital
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 218-16-3630
6. Sex: 1 [X] M 2 [ ] F
7. Aga *(In yrs. last birthday)*: 78 Yrs. — If Undar 1 Yaer: Months / Days; If Undar 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 24, 1922
9. Birthplace *(Stata or Foraign Country)*: West Virginia

Usual Residence of Decedent

10a. Stata: MD
10b. County: Allegany
10c. City, Town or Location: Rawlings
10d. Inside City Limits: 1 [ ] Yas 2 [X] No
10e. Street and Number: 23656 McMullen Highway, S.W.
10f. Zip Code: 21557
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Nevar Married 2 [X] Merried 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedant Evar in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No — If Yas, Giva Yaar or Datas: WW II
13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedant's Education *(Specify only highest grada completed)* — Elamentary/Secondary (0-12): 11 — College (1-4or 5+):
16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT use retired)*: Preparation Dept.
16b. Kind of Businass/Industry: Textile Manufacturing

17. Father's Name *(First, Middle, Last)*: Lee Fredrick Wagner
18. Mothar's Nama *(First, Middle, Maiden Sumama)*: Auda Middleton

19a. Informant's Name/Relationship *(Type, Print)*: Mary E. Wagner/ Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 23656 McMullen Highway, S.W. Rawlings, MD 21557

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or othar place)*: Sunset Memorial Park
Data: Jan. 12 2001
20c. Location - City or Town, Stete: Cumberland, MD

21. Signature of Funaral Service Licensee: Brian L Smith
22. Nama and Addrass of Facility: Smith Funeral Home 85 S. Main Street Keyser, WV 26726

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complications that caused tha daath. Do not anter tha mode of dying, such es cardiec or respiretory arrest, shock, or haart failura. List only ona cause on aach lina.

Approximate Intarval Batween Onset and Death

Immediata Causa (Final disaasa or condition resulting in death):
a. Intraabdomeral sepsis
Due to (or as a consequence of):
b. Gastric Perforation — 2d.

Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Causa (Disease or injury that initiated evants resulting in death) Last:
Dua to (or as e consequence of):
c. Renal failure — 1½ weeks
Dua to (or es a consequance of):
d. Pneumonia — 2½ weeks

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa givan in Part I.: Severe epistaxis

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No
24b. Wara autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case rafarred to medical examinar? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Othar: 4 [ ] Nursing Homa 5 [ ] Rasidance 8 [ ] Othar *(Specify)*

27. Mannar of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [X] Could not be determined

28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To tha best of my knowledge, deeth occurred at tha time, data and place, and due to the cause(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: Mark G. Nolen
29c. Licansa number: D0056355
29d. Date signed *(Month, Day, Year)*: January 9, 2001

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): Mark G. Nolen WMHS 900 Seton Dr. Cumberland MD 21502

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 17 2001
32. Registrer's Signetura: B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6

MLS

01-0366-510
crn
Anne C. Birtha ADMEND ITEM: #23 PART I, II, 27 PER MEO G794 4-4-01 WR.
Amended Item#5 perFHG791 1/26/2001 EW

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01832

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anne C. Birtha

2. Date of Death (Month, Day, Year): January 22, 2001

3. Time of Death: 1:55 P.M.

4a. Facility Name (If not institution, give street and number): 4800 Seton Drive

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-40-3022 ~~410-40-3022~~

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 56 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 01 27 44

9. Birthplace (State or Foreign Country): M.D.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1001 Spring Gate Road Apt 3C

10f. Zip Code: 21228

10g. Citizen of What Country: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade | College (1-4or 5+): 2yrs+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dental Technical

16b. Kind of Business/Industry: University of MD Dental School

17. Father's Name (First, Middle, Last): James Walker

18. Mother's Name (First, Middle, Maiden Surname): Nazabeth Richardson

19a. Informant's Name/Relationship (Type, Print): Frances L. Jones-Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1001 Spring Gate Road Apt 3C, Baltimore Md 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Vet.

Date: 1/30/01

20c. Location - City or Town, Stete: Owings Mills, Md

21. Signature of Funeral Service Licensee: Glynn B. Kelly

22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CARDIAC ARRHYTHMIA IN ASSOCIATION WITH MULTIPLE SCLEROSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

REMOTE VASCULAR ABNORMALITIES OF THE BRAIN;

PYELONEPHRITIS; SUBPLEURAL ABSCESS; OSTEOPOROSIS;

EMPHYSEMATOUS CHANGES

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): January 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mary G. Ripple, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01833

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month / Day / Year	3. Time of Death
Joseph Belon, Jr	January 14 2001	12:22pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Greater Baltimore Medical Center	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
249-24-1875	1☒ M 2☐ F	74 Yrs.			2-19-1926	N.J.

Usual Residance of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	N/A	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1218 Winston Avenue	21239	U S A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7th grade	N/A	Longshoreman	Md Port Authority

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph Belon, Sr	Dicey Moody

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Elvee Belon - Wife	1218 Winston Avenue Baltimore, Md 21239

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Dulaney Valley Memorial	1-19-01	Timonium, Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Glynna B Keke	March F/H West 4300 Wabash Avenue Baltimore, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. MYOCARDIAL INFARCTION	18 HOURS
Due to (or as a consequence of):	b. CORONARY ARTERY DISEASE	10 YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Fred Chan	D53430	JANUARY 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRED CHAN 6701 NORTH CHARLES STREET TOWSON MD 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 26 2001	▶ Donna B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01834

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hoyle Lee Benton, Jr.

2. Date of Death (Month, Dey, Yeer): January 25 2001

3. Time of Death: 12:37AM

4a. Facility Neme (If not institution, give street end number): St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 219-14-1699

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): 08/26/1924

9. Birthplace (State or Foreign Country): Maryland

Usuel Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Arbutus

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5008 Shelbourne Rd.

10f. Zip Code: 21227

10g. Citizen of What Country? United States

11. Meritel Stetus: 1☐ Never Merried 2☒ Merried 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Dates: 5/23/44 - 2/20/46

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Plumber

16b. Kind of Business/Industry: Plumbing

17. Father's Neme (First, Middle, Last): Hoyle Lee Benton, Sr.

18. Mother's Neme (First, Middle, Maiden Surname): Thelma Ann Brutsche

19a. Informant's Neme/Reletionship (Type, Print): Marie Benton/ wife

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 5008 Shelbourne Rd. Arbutus, Maryland 21227

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Loudon Park Cemetery

Dete: 1/29/01

20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Stan Ladbell

22. Neme end Address of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, Maryland 21227

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Interval Between Onset and Deeth

Immediate Cause (Finel diseese or condition resulting in deeth): a. Atherosclerotic Cardiovascular Disease — 36 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

Diverticulosis
Diverticular Bleeding
Anemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveilable prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☒ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer):

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred:

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify):

28f. Location (Street end Number or Rural Route Number, City or Town, State):

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) and menner es stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: M J Frydenberg MD

29c. License number: D0027315

29d. Dete signed (Month, Day, Yeer): January 25, 2001

30. Neme end address of person who completed ceuse of death (Item 23a) (Type, Print): M. J. Frydenberg MD St Agnes Hospital

State Registrar

31. Dete filed (Month, Day, Yeer): JAN 26 2001

32. Registrer's Signeture: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Benton, Hoyle

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #15, 18 PER F.H. G792 2-20-01 WR.
AMEND ITEMS: #10G, 18,20 PER F.H. G792 2-7-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01835

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DAVID BROTHERSON
2. Date of Death Month: 1 Day: 24 Year: 01
3. Time of Death: 1:03 PM
4a. Facility Name (If not institution, give street and number): LAUREL REGIONAL HOSPITAL
4b. City, Town, or Location of Death: LAUREL
4c. County of Death: PG

Funeral Director

5. Social Security Number: 059-64-1130
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 45 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4-13-55
9. Birthplace (State or Foreign Country): GUYANA

Usual Residence of Decedent

10a. State: MD
10b. County: PG.
10c. City, Town or Location: LAUREL
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 9113 ELAINE CT
10f. Zip Code: 20708
10g. Citizen of What Country? U.S.A ~~SOUTH AMERICA~~

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0 ~~12yrs~~ | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NEVER employed
16b. Kind of Business/Industry:

17. Father's Name (First, Middle, Last): ALBERT BROTHERSON
18. Mother's Name (First, Middle, Maiden Surname): NESTA S. SOFTLEIGH ~~NESTA SOFTLEAT~~ ~~SOFLLEIGH~~

19a. Informant's Name/Relationship (Type, Print): Nesta Brotherson mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9113 Elaine Ct. Laurel Md. 20708

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): EVERGREEN
Date: 1/29/01 ~~1-27-2001~~
20c. Location - City or Town, State: BROOKLYN N.Y

21. Signature of Funeral Service Licensee: Carlton C. Douglass
22. Name and Address of Facility: 1701 MT CLINTON ST. BALTO MD CARLTON C. DOUGLASS FUNERAL SERVICE P.A.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. acute Cardiac Arrest
Due to (or as a consequence of):
b. Cardiomyopathy

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Down's Syndrome
Cerebrovascular accident
Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one) Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D 53411
29d. Date signed (Month, Day, Year): January 24th 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J.C. Shesadri 13609 BARNET LA #32 LAUREL, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

01-0377-510
crn
Bonnie S. Baird #13
Amended Item#5 perFHG791 1/26/2001 EW

ADMEND ITEM: #9 PER VERBAL RESPONSE G793 3-14-01 WR.
AMEND ITEM: #7 PER F.H. G792 2-7-01 WR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01836

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BONNIE S. BAIRD
2. Date of Death (Month, Day, Year): January 23, 2001
3. Time of Death: 7:05 A.M.
4a. Facility Name (If not institution, give street and number): Sinai Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 328-92-6909 T127911
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 37 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 24 1963
9. Birthplace (State or Foreign Country): TOBAGO WI.

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4011 W. ROGERS AVE
10f. Zip Code: 21215
10g. Citizen of What Country? TRINIDAD & TOBAGO
11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☒ Yes 2☒ No Specify: TOBAGONIAN
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DOMESTIC
16b. Kind of Business/Industry
17. Father's Name (First, Middle, Last): DESMOND BAIRD
18. Mother's Name (First, Middle, Maiden Surname): GLENDA ANTOINE
19a. Informant's Name/Relationship (Type, Print): SANDRA BAIRD (SISTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11364 PEARKNESS DR. PLAINFIELD ILL
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): SCARBROUGH CEMETERY
Date: 2-2-01
20c. Location - City or Town, State: TRINIDAD & TOBAGO W.I.
21. Signature of Funeral Service Licensee: Carlton C. Douglas
22. Name and Address of Facility: Carlton C. Douglass Funeral Service P.A. 1701 McCulloh St. Balto.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pulmonary Thromboembolism
Due to (or as a consequence of):
b. Deep Vein Thrombosis
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: J. M. Tims
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): January 24, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TIMS, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01837

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EVELYN BOSTON
2. Date of Death (Month, Day, Year): JAN. 22 2001
3. Time of Death: 10:19am
4a. Facility Name (If not institution, give street and number): BON SECOURS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-07-5884
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 82 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 05-27-1918
9. Birthplace (State or Foreign Country): SC

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 2320 ARUNAH AVENUE
10f. Zip Code: 21216
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12TH GRADE
College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOME MAKER
16b. Kind of Business/Industry: DOMESTIC

17. Father's Name (First, Middle, Last): CLARENCE VANCE
18. Mother's Name (First, Middle, Maiden Surname): BLANCHE SCORBOROUGH

19a. Informant's Name/Relationship (Type, Print): COLLEEN BOSTON / DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 919 MARKSWORTH RD., BALTO. MD. 21228

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS MEMORIAL PARK
Date: 01-27-01
20c. Location - City or Town, State: BALTO. MD

21. Signature of Funeral Service Licensee: ▶ Daughn C
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL. PIKE, BALTO. MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — 20 MIN

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
RENAL FAILURE
DIABETES

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ S Amsel MD
29c. License number: D16347
29d. Date signed (Month, Day, Year): 1/25/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S AMSEL 1000 CATHEDRAL ST BALTIMORE, MD 21201.

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01838

BROWN, BEULAH

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): BEULAH M. BROWN
2. Date of Death (Month, Day, Year): JANUARY 23, 2001
3. Time of Death: 11:11am
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: AA COUNTY
5. Social Security Number: 217-20-3689
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC 12, 1923
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2930 ROUND ROAD
10f. Zip Code: 21225
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent oi Hispanic Origin? (Specify Yes or No- Ii Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indian, Black, White, etc. Specify: BLACK

15. Decedent'a Educetion (Specify only highest grade completed): Elementery/Secondary (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SOCIAL WORKER
16b. Kind of Business/Industry: STATE OF MD

17. Father's Name (First, Middle, Last): HENRY WALLACE
18. Mother's Name (First, Middle, Maiden Surneme): OLLIE WALLACE

19a. Informant's Name/Reletionship (Type, Pnnt): BETTY BROWN (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2830 WINWOOD CT. BALTIMORE MD 21225

20a. Method of Disposition: ☒ Buriei 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. CALVARY CEM.
Date: 1-27-2001
20c. Location - City or Town, State: BROOKLYN, MD

21. Signature of Funeral Service Licensee: ▶E.N. WALKER JR
22. Name and Address of Facility: ESTEP BROS. FUNERAL SERV. PA 1300 EUTAW PLACE BALTIMORE MD 21217

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or reapiratory arrest, shock, or heert failure. List only one ceuse on each line.

Approximate Intervai Between Onset and Death

Immediete Cause (Final diseese or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION — 1 DAY

Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE — 10 YEARS

Sequentially iist conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last

Due to (or as a consequence oi):
c. ESSENTIAL HYPERTENSION — 15 YEARS

Due to (or es e consequence of):
d. DIABETES MELLITUS — 20 YEARS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
PERIPHERAL VASCULAR DISEASE
PEPTIC ULCER
CHRONIC RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place oi Injury - At home, farm, street, iactory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner ss stated. 2☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Harjit Singh M.D
29c. License number: D14160
29d. Date signed (Month, Day, Year): JANUARY 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HARJIT SINGH MD 5410 RATCHIE HIGHWAY, BALTIMORE, MARYLAND - 21225

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: ▶ Jenna G. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 01839

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Evelyn E. Burton
2. Date of Death (Month Day Year): Jan. 16, 2001
3. Time of Death: 6:38 PM
4a. Facility Name (If not institution, give street and number): Gilcrest Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-40-9747
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 58 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4/19/1942
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Joppa
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10 Old Sound Road
10f. Zip Code: 21085
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years | College (1-4 or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Executive Secretary
16b. Kind of Business/Industry: Computer Company

17. Father's Name (First, Middle, Last): Walter Ragan
18. Mother's Name (First, Middle, Maiden Surname): Jeannette Stewart

19a. Informant's Name/Relationship (Type, Print): Carl Burton (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 Old Sound Rd. Joppa, MD 21085

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Holly Hill Memorial Gardens | Date: 1/20/2001
20c. Location - City or Town, State: Middle River, MD

21. Signature of Funeral Service Licensee: E.F. Lassahn
22. Name and Address of Facility: E.F. Lassahn Funeral Home 11750 Belair Rd Kingsville, MD 21087

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Adenocarcinoma of colon — 1 year
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: W. Anthony Riley MD
29c. License number: D25205
29d. Date signed (Month, Day, Year): January 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St Balto. md 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: James B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6:38 PM
January 16, 2001
Burton, Evelyn

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#8 PER INFMT. G792 2-1-2001 JAB

Certificate of Death

Reg. No. 2001 01840

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
PAULA	BECK	JANUARY 24, 2001	9:35 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ONE POMONA EAST #507	BALTIMORE	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
102-20-8142	1☐ M 2☒ F	72 Yrs.			~~JULY 27, 1928~~ 6-27-28	N.Y.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	BALTIMORE	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
ONE POMONA EAST #507	21208	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes ☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ABRAHAM WITTMAN	SARAH KLEINSTEIN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SAM BECK / HUSBAND	ONE POMONA EAST #507 - BALTIMORE, MD 21208

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	HAR SINAI CEMETERY	1/25/01	OWINGS MILLS, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. BREAST CANCER	11 YEARS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERCALCEMIA, BONE METASTASES

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] MD	D29373	1/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERIC J. SEIFTER, MD 10755 FALLS RD, SUITE 200 LUTHERVILLE, MD 21093

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 25 2001	[signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01841

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Marjorie Crandall
2. Date of Death (Month, Day, Year): January 20 2001
3. Time of Death: 2:30 pm
4a. Facility Name (If not institution, give street and number): Millennium Health & Rehab. at South River
4b. City, Town, or Location of Death: Edgewater
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 213-22-8870
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 12,1908
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Edgewater
10d. Inside City Limits: 1☐ Yes 2☒ No XX
10e. Street and Number: 144 Washington Road
10f. Zip Code: 21037
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Switchboard Operator
16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): Louis A. Crandall
18. Mother's Name (First, Middle, Meiden Surname): Bettie A. Dawson

19a. Informant's Name/Relationship (Type, Print): Laura D. Hays (Great-Niece)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4002 Mariner Court, Dunkirk, MD 20754

20e. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Metro Crematory
Date: 01/23 2001
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ Patrick J Arnold
22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Parkinsons Disease — unknown

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular accident
Atrial fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and placa, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: ▶ Alone Clemmo
29c. License number: D48101
29d. Date signed (Month, Day, Year): 1/22/2001

30. Name and address of person who completed cause of death (item 23a) (Type, Print): Donna Chambers MD 1833A Forest Dr Annapolis MD 21401

State Registrar

31. Dete filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature: ▶ Geneva G Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01842

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edward Frederick Drocella, Sr.

2. Date of Death — Month: January Day: 21 Year: 2001

3. Time of Death: 7:45 PM

4a. Facility Name *(If not institution, give street and number)*: Chesepeake Future Care

4b. City, Town, or Location of Death: Arnold

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 217-22-7536

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 72 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: Sept. 12 1928

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 92 Willow Brook Drive

10f. Zip Code: 21122

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 8 College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mechanic

16b. Kind of Business/Industry: Automotive

17. Father's Neme *(First, Middle, Last)*: Frank Drocella

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Mary Heath

19a. Interment's Neme/Reletionship *(Type, Print)*: Evelyn Drocella (wife)

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 92 Willow Brook Drive, Pasadena, MD. 21122

20a. Method of Disposition: 1☒Buriel 2☐Cremetion 3☐Removel from Stete 4☐Donetion 5☐Other *(Specify)*

20b. Piece ot Disposition *(Neme of cemetery, cremetory or other piece)*: Meadowridge Cemetery

Dete: 1/25/01

20c. Location - City or Town, State: Howard Co. Maryland

21. Signature of Funeral Service Licensee ▶ [signature]

22. Neme end Address of Feciility: Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Md. 21122

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. intracranial hemorrhage — weeks

Due to (or as e consequence ot):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

renal failure, hypertension

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was en autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause ot death? 1☐Yes 2☐No

25. Wes cese reterred to medicel examiner? 1☐Yes 2☒No

26. Place ot Death *(Check only one)*: Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Deeth: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigetion 6☐Could not be determined

28a. Dete ot Injury *(Month, Day Year)*

28b. Time ot Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Piece ot Injury - At home, term, street, tectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date end piece, and due to the cause(s) and manner as stated. 2☐**Medicel Examiner**: On the basis ot exemination end/or investigetion, in my opinion, deeth occurred at the time, dete end piece, end due to the ceuse(s) and menner steted.

29b. Signeture end title of certifier ▶ [signature]

29c. License number: D41955

29d. Date signed *(Month, Day, Year)*: 1-22-01

30. Neme and address of person who completed ceuse ot deeth (Item 23e) (Type, Print): Rebecca Eon MD 479 Jumpers Hole Rd Severna Park MD 21146

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 2 5 2001

32. Registrer's Signeture ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01843

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard E. Frey

2. Date of Death (Month, Day, Year): JANUARY 15 2001

3. Time of Death: 1605

4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 212-42-4053

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 55 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 16, 1945

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore City

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3122 Foster Avenue

10f. Zip Code: 21224

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bricklayer

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Edward C. Frey

18. Mother's Name (First, Middle, Maiden Surname): Mary Louise Dunkerly

19a. Informant's Name/Relationship (Type, Print): Ilene Grimmett-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3122 Foster Avenue, Baltimore, Maryland 21224

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Crematory

Date: 1-20-01

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: ▶ Lisa S. Jefferson

22. Name and Address of Facility: Loudon Park Funeral Home 3620 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Alcoholic Cirrhosis — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Gregory O. Clark, M.D.

29c. License number: RES 000

29d. Date signed (Month, Day, Year): January 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gregory Clark Johns Hopkins Hospital, 600 North Wolfe St., Baltimore Maryland 21287

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001

32. Registrar's Signature: ▶ Penny B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01844

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Theodore Raymond Fornwalt
2. Date of Death (Month, Dey, Year): Jan. 20, 2001
3. Time of Death: 8:50AM
4a. Facility Name (If not institution, give street end number): Gilcrest Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-14-7223
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Year): 9/1/1921
9. Birthplece (Stete or Foreign Country): Baltimore

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Monkton
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2433 Houcks Mill Road
10f. Zip Code: 21111
10g. Citizen of What Country?: USA

11. Merital Status: 1 [ ] Never Married 2 [ ] Merried 3 [X] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: WWII
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: white

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondery (0-12): 12 years; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Outsied Sales
16b. Kind of Business/Industry: Brady Plywood

17. Father's Name (First, Middle, Last): Peter Silvester Fornwalt
18. Mother's Neme (First, Middle, Meiden Surneme): Carrie Bernice Gorsuch

19a. Informant's Neme/Reletionship (Type, Print): Carol Bender (daughter)
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20316 Old York Rd. WhiteHall, MD 21161

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): BelAir Memorial Gardens
Dete: 1/23/01
20c. Location - City or Town, State: Bel Air, MD

21. Signature of Funerel Service Licensee: E.F. Lassahn
22. Name end Address of Facility: E.F.Lassahn Funeral Home 11750 Belair Rd. Kingsville, Md 21087

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heert failure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediete Cause (Finel diseese or condition resulting in deeth): a. ischemic cardiomyopathy — months

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest

b. Due to (or es a consequence of):

c. Due to (or es e consequenca of):

d.

Part II. Other aignificant conditiona contributing to deeth but not resulting in the underlying cause given in Pert I.: Diabetes mellitus

23b. Did tobacco uaa contributa to the cause of death? 1 [X] Yaa 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [X] Other (Specify) Hospice

27. Manner of Deeth: 1 [X] Netural 2 [ ] Accident 3 [ ] Sulcide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury et Work? 1 [ ] Yas 2 [ ] No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and placa, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, dete end placa, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: W. A. Riley MD
29c. License number: D25205
29d. Date signed (Month, Day, Year): January 22, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6301 N. Charles St. Baltimore MD 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

THEODORE Fornwalt 01 20 01 8:50 AM

01-0232-510
mnmr

Helen Gaskin AMENDED ITEM# 1 per ME G797 071001 SS
amend item 23a,27,28a,b,c,d,e,f per me G791 1/31/01 yf

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01845

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~Helen Gaskin~~ Helen Gaskins
2. Date of Death (Month, Day, Year): January 14, 2001
3. Time of Death: 432 am

4a. Facility Name (If not institution, give street and number): 1400 East Madison St. Apartment 311
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-20-9004
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 12, 1928
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 1400 E. Madison Ave. Apt. 311
10f. Zip Code: 21205
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Ira Taylor
18. Mother's Name (First, Middle, Maiden Surname): Mary Williams

19a. Informant's Name/Relationship (Type, Print): Kenneth Gaskin - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18702: 37 S. Welles Wilkes Barre, Pennsylvania

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery
Date: 1/19
20c. Location - City or Town, State: Landsdowne Maryland

21. Signature of Funeral Service Licensee: Kevin Parker
22. Name and Address of Facility: Kevin A. Parker Funeral Home 3512 Frederick Ave. Baltimore, MD. 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only ona causa on each line.

Approximeta Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SMOKE INHALATION AND THERMAL INJURIES COMPLICATED BY ATHEROXCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an eutopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yas 2☐ No

25. Was casa referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)
Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) at scene

27. Manner of Death: 1☐ Netural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): 1/14/01
28b. Time of Injury: 3:55 A M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: smoke inhalation and thermal injuries complicated by Atherosclerotic Cardiovascualr disease
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): subject was victim of a house fire
28f. Location (Street and Number or Rural Route Number, City or Town, State): 1400 E. Madison St. Baltimore, Md 21205

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and piece, and due to the cause(s) end mannar as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, end dua to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): January 14, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Mary G. Ripple, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: Jennie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2001 01846
Reg. No.

Amended Item #26 per PHYG791 1/26/01 EW

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
DOROTHY MARIE GITTINGS	January 17 2001	10:30pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1647 POOLE ROAD	DARLINGTON	HARFORD

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-22-6541	1☐ M 2☒ F	76 Yrs.			AUG 7 1924	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	HARFORD	DARLINGTON	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1647 POOLE ROAD	21034	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6th grade		SALAD CHEF	MARRIOTT HOTEL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
HERBERT GITTINGS	MARIE WHYTE GITTINGS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Gloria L. Ames/Daughter	1647 Poole Rd., Darlington, Md., 21034

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	BERKELEY CEMETERY	01-22-01	DARLINGTON, MARYLAND

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME PA
321 S. PHILADELPHIA BLVD, ABERDEEN, MD 21001

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. MYOCARDIAL INFARCTION	
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. ASCVD	1990
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
DEMENTIA OF ALZHEIMERS
ARTHRITIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☒ Emergency Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D0055143	1/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KARL SPECTOR, M.D. 2014 TOLLGATE RD Bel Air, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 26 2001	[signature]

ORIGINAL

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Dorothy Gittings 1/17/01, 10:30pm

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2001 JAN 26 AM 12:57

ADH
SHELBY J. GALLOWAY
01-0283-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS# 23b,27,28a-f per ME G795 052201 SS
AMENDED ITEMS# 23a,b,pt II,&27 per ME G792 021401 SS

Certificate of Death

Reg. No. 2001 01847

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SHELBY J. GALLOWAY

2. Date of Death: Month JANUARY Day 17, Year 2001

3. Time of Death: 1718 PM

4a. Facility Name (If not institution, give street and number): 438 SOUTH PARRISH STREET

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 411-76-4851

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 52 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): APRIL 25, 1948

9. Birthplace (State or Foreign Country): TENNESSEE

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: BALTIMORE CITY

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 438 SOUTH PARRISH STREET

10f. Zip Code: 21223

10g. Citizen of What Country?: UNITED STATES

11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): WILLIAM DURHAM

18. Mother's Name (First, Middle, Maiden Surname): ANNIE DEPEW

19a. Informant's Name/Raiationship (Type, Print): PAULA GALLOWAY RIVERA-DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7875 AMERICANA CIRCLE, GLEN BURNIE, MARYLAND 21060

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): LOUDON PARK CEMETERY

Date: 1-22-01

20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Lisa S. Jefferson

22. Name and Address of Facility: LOUDON PARK FUNERAL HOME 3620 WILKENS AVENUE, BALTIMORE, MARYLAND 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disaase or condition resulting in death)

a. CARDIAC ARRHYTHMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. HYPERTENSIVE CARDIOVASCULAR DISEASE ASSOCIATED WITH NARCOTIC INTOXICATION

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa given in Part I.: CHRONIC NARCOTISM

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was casa raterred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residenca 6☒ Other (Specify) AT SCENE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☒ Could not be determined

28a. Date of Injury (Month, Day Year) found: 1-17-01

28b. Time of Injury found: at: 5:00 PM

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): found at home

28f. Location (Street and Number or Rural Route Number, City or Town, State): 438 S. Parrish St., Balto., MD

29a. Cartifier (Check only one) 1☐ **Certifying Physician**: To tha best of my knowledge, death occurred at the tima, data and place, and dua to tha causa(s) and mannar as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, daath occurred at tha time, date and placa, and dua to the cause(s) and mannar stated.

29b. Signature end title of certifier: Dennis J Chute MD

29c. License number: OCME

29d. Date signed (Month, Day, Year): JANUARY 18, 2001

30. Name and address of person who completed cause of daath (Item 23a) (Type, Print): Dennis J Chute MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

23 PART II
AMEND ITEM: #23C PER PHY G791 1-26-01 WR.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2001 01848

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Gerber
2. Date of Death: Month: January Day: 23 Year: 2001
3. Time of Death: 955 PM
4a. Facility Name (If not institution, give street and number): Northwest Hospital Center
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-05-5574
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 81 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 11, 1919
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8180 Del Haven Road
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 8 Years; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance
16b. Kind of Business/Industry: Steel Industry Eastern Stainless

17. Father's Name (First, Middle, Last): Michael Hugo Gerber
18. Mother's Name (First, Middle, Maiden Surname): Maggie Clusman

19a. Informant's Name/Relationship (Type, Print): Margaret Ripken (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2539 Liberty Pkwy. Dundalk, Maryland 21222

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp. Date: 1/25/2001
20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Chas M Fahy
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Renal Failure — days
Due to (or as a consequence of):
b. Liver Failure — days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): ATRIAL FIBRILLATION
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
~~Hip Fracture, Atrial Fibrillation~~

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Christopher Davis MD
29c. License number: D55609
29d. Date signed (Month, Day, Year): January 23, 2001
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Christopher Davis 2401 West Belvedere Avenue Baltimore, Maryland 21215

1571

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 01849

Gerst, Frances

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): Frances K Gerst
2. Date of Death (Month, Day, Year): January 22 2001
3. Time of Death: 1202pm
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore
5. Social Security Number: 220 40 9754
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 57 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 25 1943
9. Birthplace (State or Foreign Country): Baltimore, Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore County
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4421 Ridge Road
10f. Zip Code: 21236
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 — College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired): Housewife
16b. Kind of Business/Industry: Housekeeping-Own Home
17. Father's Name (First, Middle, Last): Francis B Foard
18. Mother's Neme (First, Middle, Maiden Sumame): Katherine Wirsing
19a. Informant's Name/Relationship (Type, Print): George C Gerst (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4421 Ridge Road Baltimore, Maryland 21236
20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery — Date: January 25 2001
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: Heather Lassahn Chonacki
22. Name and Address of Facility: Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter tha diseasa, or complications that causad the death. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Final disease or condition resulting in death)
a. Acute Dysrhythmia
Due to (or es e consequence of):
Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last
b. Coronary Artery Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.

Diabetes Mellitus, Chronic Renal failure
Congestive Heart failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. Licensa number: D0055791
29d. Date signed (Month, Day, Year): 1/22/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR Kevin Smothers 9000 Franklin Square Drive Baltimore Maryland 21237

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: Geneva B. Hawks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01850

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MONROE WALLACE HILL
2. Date of Death (Month, Day, Year): JAN. 23, 2001
3. Time of Death: 3:35am

4a. Facility Name (If not institution, give street and number): GENESIS ELDER CARE
4b. City, Town, or Location of Death: SAVERNA PARK
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 219-52-6536
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 52 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 18, 1949
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: PASADENA
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8013 OUTING AVE.
10f. Zip Code: 21122
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): GLASS MECHANIC
16b. Kind of Business/Industry: DONALDSON GLASS & MIRROR

17. Father's Name (First, Middle, Last): JAMES FLETCHER HILL
18. Mother's Name (First, Middle, Maiden Surname): BERNIECE ELIZABETH ISENNOCK

19a. Informant's Name/Relationship (Type, Print): CAROL S. HILL (WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8013 OUTING AVE., PASADENA, MD 21122

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): LOUDON PARK CEMETERY
Date: 1/25/01
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: LOUDON PARK FUNERAL HOME 3620 WILKENS AVE., BALTIMORE, MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximeta Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Renal Cell Cancer - Metastatic — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ John F. Roome, MD
29c. License number: D52728
29d. Date signed (Month, Day, Year): January 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John F. Roome, MD 479 Jumpers Hole Road #304 Saverna Park, MD 21146

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01851

Hudson, Nellie 1-22-2001 4:10pm MANOR CARE ROSSVILLE BALTO MD 21237

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: NELLIE M. HUDSON
2. Date of Death Month: JAN. Day: 22 Year: 2001
3. Time of Death: 4:10 PM
4a. Facility Name *(If not institution, give street and number)*: Manor Care-Rossville
4b. City, Town, or Location of Death: Rossville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 383-24-4672
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 101 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 1-27-1899
9. Birthplace *(State or Foreign Country)*: Kentucky

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore County
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7011 Ridge Rd.
10f. Zip Code: 21236
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th grade — College (1-4or 5+): N/A
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife
16b. Kind of Business/Industry: Homemaking-Own Home

17. Father's Name *(First, Middle, Last)*: James Prewitt
18. Mother's Name *(First, Middle, Maiden Surname)*: Susan Oliver

19a. Informant's Name/Relationship *(Type, Print)*: Rosslee H. Dixon (Daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7011 Ridge Rd. Baltimore, Md. 21236

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Gardens of Faith Cem. — Date: 1-26-01
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: ▶ E. F. Lassahn
22. Name and Address of Facility: Lassahn Funeral Home 7401 Belair Rd. Baltimore, Maryland 21236

Physician /Medical Examiner

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Cerebral hemorrhage
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Liya Pfeffers
29c. License number: D35410
29d. Date signed *(Month, Day, Year)*: January 23, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type/Print): LIYA PFEFFERS 6918 RIDGE ROAD BALTIMORE, MARYLAND 21237

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 26 2001
32. Registrar's Signature: ▶ Brenda B. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01852

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Raleigh Henley

2. Date of Death: Month: January Day: 23 Year: 2001

3. Time of Death: 10:46 AM

4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-34-8127

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 60 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC 24, 1940

9. Birthplace (State or Foreign Country): md.

Usual Residence of Decedent

10a. State: md

10b. County: N/A

10c. City, Town or Location: BALTO.

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1619 MONTFORD AVE

10f. Zip Code: 21213

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER

16b. Kind of Business/Industry: odd JOBS

17. Father's Name (First, Middle, Last): RALEIGH L. HENLEY, SR.

18. Mother's Name (First, Middle, Maiden Surname): NELLIE HAMMETT

19a. Informant's Name/Relationship (Type, Print): ROBERTA HENLEY / SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3651 PARK HEIGHTS AVE 1ST FLOOR - BALTO, MD. 21215

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): VOSHELL MEMORIAL GARDENS

Date: 1/30/01

20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: Jewell Mcmartie

22. Name and Address of Facility: BETTS FUNERAL HOME 1129 N. CAROLINE ST - BALTO, MD. 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	ventricular fibrillation arrest	1 minute
Due to (or as a consequence of): b.	ischemic injury to heart	10 hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	type A aortic dissection	20 hours
d.	hypertensive emergency	20 hours

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: cerebrovascular accident due to type A aortic dissection

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Carolyn Wong M.D.

29c. License number: RES-000

29d. Date signed (Month, Day, Year): January 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Carolyn Wong 601 North Wolfe Street Baltimore, Maryland 21287

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001

32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indellble Ink. Assure All Copies Are Legible.

AMEND ITEM: #15 PER F.H. G792 2-14-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01853

NAME: RAYMOND KAHN
Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Raymond S. Kahn
2. Date of Death (Month, Day, Year): JANUARY 23 2001
3. Time of Death: 1.05AM
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 109-05-3799
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 8, 1912
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Severna Park
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 815 Benfield Road
10f. Zip Code: 21146
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Therapist
16b. Kind of Business/Industry: Radiation

17. Father's Name (First, Middle, Last): Emile Kahn
18. Mother's Name (First, Middle, Maiden Surname): Marguerite Gondscheaox

19a. Informant's Name/Relationship (Type, Print): Eric M. Kahn (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): PO Box 103, Severna Park, MD 21146

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Menorah Gardens
Date: 01/26 2001
20c. Location - City or Town, State: W. Palm Beach, FL

21. Signature of Funeral Service Licensee: Patrick J. Hardesty II
22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert fellure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. PNEUMONIA
Due to (or as a consequence of):
b. RESPIRATORY FAILURE
Due to (or as a consequence of):
c. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D45149
29d. Date signed (Month, Day, Year): JANUARY 23 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ONABAJO. B 301 HOSPITAL DRIVE GLEN BURNIE MD 2106

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01854

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGARET FRANCES KEILHOLTZ
2. Date of Death (Month, Day, Year): JAN. 19TH 2001
3. Time of Death: 16:18
4a. Facility Name (If not institution, give street and number): 4705 FREDERICK AVENUE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Number: 214-22-7754
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): November 13, 1926
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore City
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4705 Frederick Avenue
10f. Zip Code: 21229
10g. Citizen of What Country?: United States
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): Phillip Weinberg
18. Mother's Name (First, Middle, Maiden Surname): Ethel Steinback
19a. Informant's Name/Relationship (Type, Print): Henry L. Keilholtz
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4705 Frederick Avenue, Baltimore, Maryland 21229
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery
Date: 1-23-01
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: ▶ Lisa S. Jefferson
22. Name and Address of Facility: Loudon Park Funeral Home, 3620 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. GASTRIC LYMPHOMA — MONTHS

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ M Vasanthakumar MD
29c. License number: D 42510
29d. Date signed (Month, Day, Year): JAN 19TH 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. VASANTHAKUMAR, MD 821 N. EUTAW ST # 407 MD 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: ▶ Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01855

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HENRY J. KAHN

2. Date of Death (Month, Day, Year): JANUARY 24 2001

3. Time of Death: 11:15 AM

4a. Facility Name *(If not institution, give street and number)*: NORTHWEST HOSPITAL

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-32-9928

6. Sex: XX 1☐ M 2☐ F

7. Age *(In yrs. last birthday)*: 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: FEB. 13, 1928

9. Birthplace *(State or Foreign Country)*: GERMANY

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: RANDALLSTOWN

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3925 SADIE ROAD

10f. Zip Code: 21133

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MANAGER

16b. Kind of Business/Industry: FURNITURE STORE

17. Father's Name *(First, Middle, Last)*: MAX KAHN

18. Mother's Name *(First, Middle, Maiden Surname)*: SELMA GRUNEBAUM

19a. Informant's Name/Relationship *(Type, Print)*: EDGAR KAHN / SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 313 BRUSHWOOD DRIVE - OWINGS MILLS, MD 21117

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CHEVRA AHAVAS CHESED

Date: 1/25/01

20c. Location - City or Town, State: RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC COLON CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] C. Ravi MD

29c. License number: D37333

29d. Date signed *(Month, Day, Year)*: JANUARY 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C. RAVI MD, NHC, BALTO. MD 21133

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01856

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARTHA D. KESSLER
2. Date of Death (Month, Day, Year): JANUARY 24, 2001
3. Time of Death: 1:26 AM
4a. Facility Name *(If not institution, give street and number)*: SINAI HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-24-9728
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 71 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: FEB.25,1929
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: OWINGS MILLS
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4 NOBILITY COURT #D
10f. Zip Code: 21117
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CLERK
16b. Kind of Business/Industry: GROCERY STORE

17. Father's Name *(First, Middle, Last)*: ISIDORE DUBANSKY
18. Mother's Name *(First, Middle, Maiden Surname)*: RAY SUSSMAN

19a. Informant's Name/Relationship *(Type, Print)*: NORMAN KESSLER / HUSBAND
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4 NOBILITY COURT #D - OWINGS MILLS, MD 21117

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: BETH JACOB CEMETERY
Date: 1/25/01
20c. Location - City or Town, State: FINKSBURG, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pulmonary Embolism	6 hours
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Renal failure, Diabetes

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Elliot Rothschild
29c. License number: D51426
29d. Date signed *(Month, Day, Year)*: January 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Elliot Rothschild 4000 Old court Rd, Pikesville

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001
32. Registrar's Signature: [signature]

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#5 perFHG791 1/26/2001 EW

Certificate of Death

Reg. No. 2001 01857

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Betty Bernice Lawrence

2. Date of Death: Month 1 Day 23 Year 01

3. Time of Death: 4 AM

4a. Facility Name (If not institution, give street and number): 1234 Maple Leaf Court

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 051-28-~~2314~~2413

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11/28/1933

9. Birthplace (State or Foreign Country): Virginia

Usual Residance of Decedent

10a. Steta: Maryland

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yas 2☐ No

10a. Street and Number: 1234 Maple Leaf Court

10f. Zip Code: 21202

10g. Citizen of What Country? U.S.A.

11. Maritel Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yas 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highast grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Homemaker

17. Father's Name (First, Middle, Last): Rufus Crosby

18. Mother's Neme (First, Middle, Meiden Surneme): Maryland Harrison

19a. Informant's Name/Ralationship (Type, Print): Wanda Lawrence / Daughter

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 6002 Amberwood Dr., Baltimore, Maryland 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Steta 4☐ Donetion 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cematery, cremetory or other place): Mt. Zion Cemetery

Data: 01/29/01

20c. Location - City or Town, Stata: Landsdowne, Maryland

21. Signature of Funaral Service Licensee:

22. Nama and Address of Facility: Derrick C. Jones Funeral Home 4611 Park Heights Ave., Baltimore, Maryland 21215

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Pert1. Entar tha disaasa, or complications that caused the death. Do not enter tha mode of dying, such as cardiec or respiretory arrest, shock, or haert failure. List only one causa on each lina.

Approximete Interval Between Onset end Death

Immediate Ceuse (Finel diseasa or condition rasulting in death): a. metastatic Bladder cancer — 2 years

Dua to (or as a consequence of):

Sequantially list conditions, If any, laading to immadiata causa. Entar Underlying Ceuse (Disease or Injury that initiated evants rasulting in death) Last:

b.

Dua to (or as a consequence of):

c.

Dua to (or es a consequence of):

d.

Part II. Other afgnificant conditiona contributing to death but not rasulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☑ Unknown

24a. Wes en eutopsy performed? 1☐ Yas 2☑ No

24b. Wara autopsy findings available prior to complation of cause of death? 1☐ Yas 2☐ No

25. Was casa rafarred to medical axaminar? 1☐ Yas 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Mannar of Death: 1☑ Neturel 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifiar (Check only one): 1☑ Certifying Physician: To tha best of my knowledge, deeth occurred at the time, date and place, end due to tha cause(s) and mannar as stated. 2☐ Medical Examiner: On the basis of axaminetion and/or invastigation, in my opinion, daath occurred at tha tima, deta and piece, and due to tha cause(s) and mannar stated.

29b. Signatura and titla of certifier:

29c. License number: 030377

29d. Date signed (Month, Day, Year): 1/23/01

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print): Robert M. Cooper MD 6503 Park Heights Ave Balt. MD 21215

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Data filed (Month, Day, Year): JAN 26 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01858

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert J. Lewis
2. Date of Death (Month, Day, Year): January 19, 2001
3. Time of Death: 1247 AM
4a. Facility Name (If not institution, give street and number): Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-20-5888
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 24, 1925
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1307 Druid Hill Ave, 2nd Floor
10f. Zip Code: 21217
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chef
16b. Kind of Business/Industry: Food Industry

17. Father's Name (First, Middle, Last): Raymond T. Lewis Sr.
18. Mother's Name (First, Middle, Maiden Surname): Alta Virginia Cross

19a. Informant's Name/Relationship (Type, Print): Mr. William Lewis (Brother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3303 Windsor Blvd. Balto. Md. 21207

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest | Date: 1/26/2001
20c. Location - City or Town, State: Owings Mills, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. Hyper Kalemia
Due to (or as a consequence of):
b. Renal Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease, Rhabdomyolysis, Pneumonia, Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D 2054
29d. Date signed (Month, Day, Year): 1/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Syed Haque, M.D. c/o Maryland General Hospital.

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: L. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Robert Johnson

AMEND ITEM: #30 PER D.V.R. G792 2-6-01 WR.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 01859

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Goldie ELIZABETH Molock
2. Date of Death Month Day Year: JAN. 23 2001
3. Time of Death: 11:30 PM
4a. Facility Name (If not institution, give street and number): GENESIS Eldercare - Randallstown
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218 26 2484
8. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 85 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC. 14, 1915
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1233 BOYLAND STREET
10f. Zip Code: 21230
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): JOHN JOHNSON
18. Mother's Name (First, Middle, Maiden Surname): Julia Lightfoot

19a. Informant's Name/Relationship (Type, Print): OLIVER MOLOCK / SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133: 5 NAIMAN Court RANDALLSTOWN, MARYLAND

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): KING MEMORIAL PARK
Date: 1-26-2001
20c. Location - City or Town, State: WOODLAWN, MARYLAND

21. Signature of Funeral Service Licensee: Leroy Harris
22. Name and Address of Facility: CHATMON - HARRIS FUNERAL HOME 5240 REISTERSTOWN ROAD BALTIMORE, MARYLAND 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Coronary Artery Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Dementia

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
28. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Shalini Tewari MD
29c. License number: D52671
29d. Date signed (Month, Day, Year): January 25, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHALINI TEWARI GENSIS-ELDERCARE RANDALLSTOWN

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: Regina D. Lowery

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 01860

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
EARL	MORGAN		JAN.	23	2001	15:40 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1001 PENNSYLVANIA AVE	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
100 18 7251	1☒M 2☐F	78 Yrs.					JAN. 4, 1923	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	N/A	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1001 PENNSYLVANIA AVE Apt. 201	21201	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	LABORER	PRIVATE INDUSTRY
8TH GRADE			

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
CHARLES S. MORGAN	MARGARET KNIGHT

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JOSEPH E. MORGAN, SR / BROTHER	8 CLEAR LAKE LANE BALTIMORE, MD 21220

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	HOLLY HILLS MEMORIAL PARK	1-30-2001	ESSEX, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ JERRY HARRIS	JONATHAN HARRIS FUNERAL HOME 5748 REISTERSTOWN ROAD BALTIMORE, MD 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CORONARY ARTERY DISEASE	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	
	c. Due to (or as a consequence of): HYPERTENSION	
	d. Due to (or as a consequence of):	

If FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☑Unknown	1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☑Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D17537	1-25-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PARSHAN S. SALUJA 1600 W. MOUNT ROYAL AVE, BALTIMORE MD 21217

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 26 2001	▶ [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Item 31 per FRG79101/26/01dhb

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01861

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jesse Brooks Manship, Jr.

2. Date of Death (Month, Day, Year): January 24, 2001

3. Time of Death: 11:30 PM

4a. Facility Name (If not institution, give street and number): 1356 Triwater Court

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 213-34-7857

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 25, 1937

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1356 Triwater Court

10f. Zip Code: 21226

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Switchman

16b. Kind of Business/Industry: COMUNICATIONS

17. Father's Name (First, Middle, Last): Jesse Brooks Manship, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Mary Tart

19a. Informant's Name/Relationship (Type, Print): Karen Harris/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 516 First Ave. S.W. Glen Burnie, MD 21061

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Glen HAven Mem. PArk

Date: Jan. 27, 2001

20c. Location - City or Town, State: Glen Burnie, MD

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: Kirkley-Ruddick Funeral Home P.A. 421 Crain Hwy. S.E. Glen Burnie, MD 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):

a. Atherosclerotic cardiovascular Disease — 20yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: K Lins MD

29c. License number: D33441

29d. Date signed (Month, Day, Year): January 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kenneth Williams 1120 N. Rolling Rd

State Registrar

31. Date filed (Month, Day, Year): ~~Jan. 26 01~~ JAN 26 2001

32. Registrar's Signature: Bonnie B. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01862

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Manning
2. Date of Death: Month Jan Day 24 Year 2001
3. Time of Death: 4:30 pm
4a. Facility Name (If not institution, give street and number): Harbor Hospital Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-28-9348
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02-14-1933
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 2857 SEAMON AVENUE
10f. Zip Code: 21225
10g. Citizen of What Country? USA

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☐ Widowed 4☑ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE | College (1-4or 5+): N/A
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): OPERATOR
16b. Kind of Business/Industry: BELL ATLANTIC

17. Father's Neme (First, Middle, Last): WILLIAM PENN
18. Mother's Neme (First, Middle, Meiden Surname): MARY DEFREITAS

19a. Informant's Name/Reletionship (Type, Print): JOSEPH PARKS / SON
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1807 ORIOLE CT. , SEVERN , MD. 21144

20a. Metpod of Disposition: 1☑ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other piece): MT. CALVARY CEMETERY | Date: 1-30-01
20c. Location - City or Town, State: GLEN BURNIE , MD
21. Signature of Funeral Service Licensee: ▶ Vaughn C Greene
22. Name end Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE, 5151 BALTO. NATL. PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on eech line. (Approximete Intervel Between Onset end Death)

Immediate Cause (Final disease or condition resulting in deeth)
a. Ischemic Cardiomyopathy.
Due to (or es e consequence of):
b. CVA (Cerebro vascular Accident) — 2 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last
Due to (or es e consequence of):
c. CHF (congestive Heart failure)
Due to (or es e consequence of):
d. AICD pace maKer.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Arthritis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown
24e. Wes an eutopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Deeth (Check only one): Hospitel: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manger of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
26a. Dete of Injury (Month, Day Yeer)
26b. Time of Injury M
26c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end place, end due to the cause(s) and menner stated.

29b. Signature and title of certifier: ▶ S.A. Reza Jalali
29c. License number: AS2441614A56
29d. Date signed (Month, Day, Year): Jan. 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Seyed A. Jalali 3001 South Hanover, Baltimore, MD 21225

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: Lenora G. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as per page.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01863

5:35 AM JANUARY 23, 2001 CLEM MOSLEY

Physician /Medical Examiner | **Funeral Director**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Dey Yeer	3. Time of Death
CLEM MOSLEY	January 23 2001	5:35am

4a Facility Name (If not institution, give street end number)	4b. City, Town, or Location of Death	4c. County of Death
JOSEPH RICHIE HOSPICE	BALTIMORE	N/A

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Dey, Year)	9. Birthplace (State or Foreign Country)
216-42-9330	1☒M 2☐F	55 Yrs.			FEB 28 1945	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	N/A	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1521 LEMON STREET	21230	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9th grade		LABORER	SELF EMPLOYED

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
CLEM MOSLEY SR.	VIRGINIA CHANDLER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Henry W. Mosley/Brother	3824 Offutt Rd., Randallstown, Md., 21133

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremetion 3☐Removal from Stete 4☐Donation 5☐Other (Specify)	CREST LAWN CEMETERY	1-25-01	MARRIOTTSVILLE, MD.

21c. Signature of Funeral Service Licensee: Charles N. Pond

22. Neme end Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME PA, 1206 W NORTH AVENUE

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final diseesa or condition resulting in death)	a. Carcinoma of lung with mets	3mo
	Due to (or as a consequence of):	
Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or es e consequence of):	
	c. Due to (or es a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Wes an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospice

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
John W. Payne MD	D1012	Jan 23, 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John W. Payne MD 4545 N. Charles St. 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 26 2001	P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01864

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Bernadine Elizabeth McAllister
2. Date of Death Month Day Year: Jan. 22, 2001
3. Time of Death: 9:45 AM
4a. Facility Name *(If not institution, give street and number)*: Stella Marris Hospice
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-26-5661
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 72 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 11/13/1928
9. Birthplace *(State or Foreign Country)*: Baltimore, MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Kingsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6938 New Cut Road
10f. Zip Code: 21087
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 Years; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Accounts Payable Clerk
16b. Kind of Business/Industry: Black & Decker Corporation

17. Father's Name *(First, Middle, Last)*: Charles J. McAllister Sr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Doyle

19a. Informant's Name/Relationship *(Type, Print)*: Sharon Bower (neice)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6938 New Cut Rd. Kingsville, MD 21087

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Joseph's Church Cemetery
Date: 1/25/2001
20c. Location - City or Town, State: Fullerton, MD

21. Signature of Funeral Service Licensee: E.F. Lassahn
22. Name and Address of Facility: E.F. Lassahn Funeral Home 11750 Belair Rd Kingsville, MD 21087

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. BREAST CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D43725
29d. Date signed *(Month, Day, Year)*: 1/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 26 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

JANUARY 22, 2001 9:45 a.m.

BERNADINE MCALLISTER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01865

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Morant Jr.
2. Date of Death Month: JANUARY Day: 24 Year: 2001
3. Time of Death: 8:45pm
4a. Facility Name (If not institution, give street and number): SINAI Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 250-36-3319
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 71 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 23, 1929
9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 510 Lyndhurst St.
10f. Zip Code: 21229
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 8
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teamster
16b. Kind of Business/Industry: Valley Protein

17. Father's Name (First, Middle, Last): Robert Morant Sr.
18. Mother's Name (First, Middle, Maiden Surname): Louise

19a. Informant's Name/Relationship (Type, Print): (daughter) Ms. Cozetta Bessick
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6612 Bowman Hill Drive Balto. Md. 21207

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Mem. Park
Date: 1/31/2001
20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
a. Myocardial Infarction
Due to (or as a consequence of):
b. Hypertension
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Diabetes mellitus
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
End Stage Renal Disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner steted.
29b. Signeture end title of certifier: Physician
29c. License number: D0054558
29d. Date signed (Month, Dey, Year): January 24, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Frederik Burk, Jr, MD 2401 W. Belvedere Balt, MD 21215

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: Jenna D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and appropriately filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Morant, Robert

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item 23bper Dr.G791,01/26/01dhb

Certificate of Death

Reg. No. 2001 01866

Mitchell, Charles

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Robert Mitchell
2. Data of Death Month: January Day: 5 Year: 2001
3. Time of Death: 1000 PM
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 236 03 2134
6. Sex: 1 [ ] M 2 [X] F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 16 1917
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Carroll County
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7257 Lake Hills Court
10f. Zip Code: 21104
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): Computer Programmer
16b. Kind of Business/Industry: Social Security Administratio

17. Father'a Name (First, Middle, Last): Ellis Lee Mitchell
18. Mothar'a Name (First, Middle, Maiden Surname): Densie Amanda Murphy

19a. Informant's Name/Relationship (Type, Print): Linda K Maltz (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9848 Softwater Way Columbia, Maryland 21046

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Cem. | Date: January 8 2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Martha Joseph Chojacki
22. Name and Address of Facility: Lassahn Funeral Home INc 7401 Belair Road Baltimore, Maryland 21236

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the diaaasa, or complications that aeused tha daath. Do not antar the mode of dying, such as cardiac or raspiratory arrest, ahock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Ceusa (Final disease or condition resulting in death): a. Acute Renal Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last:
b. Metastactic Prostate Cancer
Due to (or es e consequence of):
c.
Dua to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. Did tobacco uee contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No
24b. Were autopsy findings aveilable prior to compiation of cause of death? 1 [ ] Yas 2 [ ] No

25. Was case referred to medicat examiner? 1 [ ] Yas 2 [X] No
26. Plece of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Deth: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and mannar as stated.
2 [ ] **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, dete and ptace, end due to tha cause(s) and manner stated.

29b. Signature and title of certifier: Charles E Roessler MD
29c. License number: D20390
29d. Date signed (Month, Day, Year): 01/07/2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): CHARLES F. HOESCH M.D. ; 9712 BELAIR RD; BALTO. MD. 21236

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signatura: Donna B. Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM 27 per phys G796 062801 SS

Certificate of Death

Reg. No. 2001 01867

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death (Month, Day, Year)	3. Time of Death
EVELYN	LOWE	NEIDERT	January 25th 2001	7:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NORTH ARUNDEL HOSPITAL	Glen Burnie	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (If yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-20-9863	1☐ M 2☒ F	81 Yrs.			AUG. 22, 1919	VIRGINIA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ANNE ARUNDEL	MILLERSVILLE	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
405 OBRECHT ROAD	21108	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	SCHOOL TEACHER	EDUCATION

17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)		
HERBERT	BAXTER	LOWE	CORA	FRANCES	POWERS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MR. HOWARD NEIDERT (HUSBAND)	405 OBRECHT ROAD, MILLERSVILLE, MARYLAND 21108

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	MEADOWRIDGE MEMORIAL PARK	1/27/2001	ELKRIDGE, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature] #01220	SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute myocardial infarction	Hour
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Acute Hepatitis	Days
Due to (or as a consequence of):		
	c. Hyperkalemia	Hours
Due to (or as a consequence of):		
	d. Hypothyroidism	Days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Mitral Valve Replacement
coronary artery bypass

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ ~~Could not be determined~~		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	D 46761	January 25th 2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print) DARIUS M. CAMERON
301 Hospital Drive. Glen Burnie, MD 21061

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 26 2001	[signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

EVELYN NEIDERT
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01868

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROBIN A. PRIMEAUX

2. Date of Death Month / Day / Year: JANUARY 23 2001

3. Time of Death: 12:10 P.M.

4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 220-86-0569

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 39 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: OCT. 24, 1961

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 861 BETHUNE ROAD

10f. Zip Code: 21225

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CASHIER/EMPLOYEE

16b. Kind of Business/Industry: FAST FOOD RESTAURANTS

17. Father's Name *(First, Middle, Last)*: LAMOTTE PRIMEAUX

18. Mother's Name *(First, Middle, Maiden Surname)*: LINDA PRIMEAUX

19a. Informant's Name/Relationship *(Type, Print)*: LINDA PRIMEAUX (MOTHER)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 861 BETHUNE RD BALTIMORE MD 21225

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MT. ZION CEM. Date: 1-29-2001

20c. Location - City or Town, State: BALTO. MD

21. Signature of Funeral Service Licensee: ▶ E.N.WALKER JR.

22. Name and Address of Facility: ESTEP BROTHERS FUNERAL SERVICE PA 1300 EUTAW PL. BALTO. MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. CHRONIC RENAL FAILURE

Due to (or as a consequence of):
b. DIABETES MELLITUS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of):
c. CEREBRO VASCULAR ACCIDENT

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: D43977

29d. Date signed *(Month, Day, Year)*: January 23 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Apex Examining 301 Hospital Drive, Glen Burnie MD. 21061.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 26 2001

32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

ROBIN PRIMEAUX
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01869

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Johnny Porter
2. Date of Death (Month, Day, Year): Jan. 25, 2001
3. Time of Death: 11:55 AM
4a. Facility Name (If not Institution, give street and number): Howard County
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 214-32-5744
6. Sex: XX M 2☐ F
7. Age (In yrs. last birthday): 72 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 06-20-28
9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☐ No XX
10e. Street and Number: 5445 Belle Vista Avenue
10f. Zip Code: 21206
10g. Citizen of What Country: USA
11. Marital Status: 1X Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No XX — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes XX No — Specify:
14. Race - American Indian, Black, White, etc. — Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th Grade — College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self-employed
16b. Kind of Business/Industry: Self-employed
17. Father's Name (First, Middle, Last): Willie Porter
18. Mother's Name (First, Middle, Maiden Surname): Lucy Cooper
19a. Informant's Name/Relationship (Type, Print): Ronald Gardner
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7 Goodola View Court Woodstack, Maryland 21163
20a. Method of Disposition: 1☐ Burial 2X Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Cemetery
Date: 01-26-2001
20c. Location - City or Town, State: Baltimore, MD
21. Signature of Funeral Service Licensee: Gladys Warner
22. Name and Address of Facility: Marsh Funeral Hm. 1101 E. North Ave

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis — 9 days
Due to (or as a consequence of):
b. Peritonitis
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Lung Mass, Illeus, Respiratory Insufficiency, Leukocytosis, Multi-Infarct Dementia, Seizure Disorder

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D46120
29d. Date signed (Month, Day, Year): Jan. 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): F Decesare 10724 Little Patuxent Pkwy. Columbia MD 21044

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: Geneva A. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

DHMH 16 Rev 6/95

ORIGINAL

2001 01870

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

IMPORTANT: If item 29 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

IF THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

IF THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GLORIA SWANSON PULLEY
2. DATE OF DEATH (Month, Day, Year): JAN. 20, 2001
3. TIME OF DEATH: 10:06P M
4. SOCIAL SECURITY NUMBER: 219-22-9714
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 73 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): July 4, 1927
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): LORIEN - FRANKFORD NURSING HOME
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH: N/A

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: N/A
10c. CITY, TOWN OR LOCATION: BALTIMOR
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3406 CALLOWAY AVENUE
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE
16b. KIND OF BUSINESS/INDUSTRY: OWN HOME
17. FATHER'S NAME (First, Middle, Last): CECIL WIDGEON
18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY HOPKINS
19a. INFORMANT'S NAME (Type/Print): JOHN PULLEY SON
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2454 KEYWORTH AVE BALTIMORE, Md 21215
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion Cemetery — DATE: 1-26-2001
20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lucy Harris
22. NAME AND ADDRESS OF FACILITY: CHARLTON-HARRIS FUN. HM. 5249 REISTERSTOWN ROAD BALTIMORE, Md 21215

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cerebrovascular Accident-	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabitis mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY M
26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
26d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D43725
29d. DATE SIGNED (Month, Day, Year): ▶ 1/24/01
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): TARIQ MAHMOOD 201-109 Back River Neck Road Baltimore MD 21221
31. DATE FILED (Month, Day, Year): JAN 26 2001
32. REGISTRAR'S SIGNATURE

DHMH 16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01871

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANNA MAE EVERETT REID
2. Date of Death — Month: JAN. Day: 23 Year: 2001
3. Time of Death: 8:45AM
4a. Facility Name (If not Institution, give street and number): SUBURBAN HOSPITAL
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONT

Funeral Director

5. Social Security Number: 239-34-4485
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 75 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 9 1925
9. Birthplace (State or Foreign Country): N.C.

Usual Residence of Decedent

10a. State: N/A
10b. County: N/A
10c. City, Town or Location: WASHINGTON, DC
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 1140 N. CAPITAL ST. NW.
10f. Zip Code: 20002
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 5TH
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): NELSON EVERETT
18. Mother's Name (First, Middle, Maiden Surname): SADIE SHORT

19a. Informant's Name/Relationship (Type, Print): LEICESTER REID (HUSBAND)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1140 N. CAPITAL ST. WASHINGTON, D.C. 20002

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ROSE HILL CEMETERY
Date: 1-31-01
20c. Location - City or Town, State: LINDEN, NJ

21. Signature of Funeral Service Licensee: Carlton C. Douglass
22. Name and Address of Facility: Carlton C. Douglass Funeral Service P.A. 1701 McCulloh St. Balto. Md. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. UROSEPSIS
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ASPIRATION PNEUMONIA, DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Elliot K. Goldstein MD
29c. License number: D03581
29d. Date signed (Month, Day, Year): January 23 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ELLIOT K GOLDSTEIN 9410 OLD GEORGETOWN RD

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: Deanna S. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

ANNA EVERETT 1/23/01 0845

01-0360-045
crn
Donald Riley

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01872

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Donald Patrick Riley, Jr.

2. Date of Death (Month, Day, Year): January 22, 2001

3. Time of Death: 3:20 A.M.

4a. Facility Name *(If not institution, give street and number)*: Peninsula Regional Medical Center

4b. City, Town, or Location of Death: Salisbury

4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 219-80-8079

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 39 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 7 1961

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 307 Oakleigh Avenue

10f. Zip Code: 21061

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Painter

16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: Donald P. Riley, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Eva Rother

19a. Informant's Name/Relationship *(Type, Print)*: Margaret E. Horrocks (mother)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 307 Oakleigh Ave., Glen Burnie, MD. 21061

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holy Cross Cemetery

Date: Jan. 26 2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Stallings Funeral Home, P.A. 3111 Mountain Rd., Pasadena, MD. 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*: 1/22/01

28b. Time of Injury: 0011 HR

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: Subject driving vehicle involved in collision accident

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Roadway

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: Pittsville Maryland

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.

29c. License number: O.C.M.E.

29d. Date signed *(Month, Day, Year)*: January 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Theodore M. King 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item # 4a,10e,19b, per FH & Dr, G791,1/30/2001 gap gap

Certificate of Death

Reg. No. 2001 01873

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
JESSE REEVES	JANUARY 23, 2001	0230

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
~~806 BEARFIELD ESTATES CT.~~ 806 Fairfield Estates Ct.	CROWNSVILLE	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
408.26.7952	1☒ M 2☐ F	82 Yrs.			FEB 17, 1918	TN

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	ANNE ARUNDEL	CROWNSVILLE	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
~~806 BEARFIELD ESTATES CT.~~ 806 Fairfield Estates Ct.	21032	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
UNK		GLASS WORKER	FORD GLASS PLANT

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
MARVIN E. REEVES, SR.	MATTIE MARTIN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ALAN B. REEVES	~~806 BEARIELD ESTATES CT.~~ CROWNSVILLE, MD 21032 806 Fairfield Estates Ct.

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	WOODLAWN CROSS MAUSOLEUM	1.26.01	NASHVILLE, TN.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
K. GREGORY FINK	FINK FUNERAL HOME,P.A. 426 CRAIN HWY S. GLEN BURNIE, MD 21061

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. pneumonia, bilateral	5 days
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	018508	01-23-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
1600 South Crain Highway Suite 106 Glen Burnie Md. 21061

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 26 2001	Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01874

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lawrence James Roberts, Sr.

2. Date of Death Month: January Day: 14 Year: 2001

3. Time of Death: 0333

4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 216-18-5421

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: February 25, 1922

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Washington

10c. City, Town or Location: Clear Spring

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 11408 National Pike

10f. Zip Code: 21722-1629

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Inspector

16b. Kind of Business/Industry: Truck Manufacture

17. Father's Name *(First, Middle, Last)*: William Edward Roberts

18. Mother's Name *(First, Middle, Maiden Surname)*: Grace Fletcher

19a. Informant's Name/Relationship *(Type, Print)*: Carolyn Kay Hauver/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 17507 Stone Valley Road Hagerstown, MD 21740

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Shanktown Cemetery

Date: 1/16/2001

20c. Location - City or Town, State: Big Pool, MD

21. Signature of Funeral Service Licensee: Richard [illegible]

22. Name and Address of Facility: Grove Funeral Home, P.A. 141 W. Main St. Hancock, MD 21750-0368

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Roberts, Lawrence James Sr.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ADVANCED LIVER CANCER. — 4 Months

Due to (or as a consequence of):

b. RENAL FAILURE. — 2 WEEKS.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. CACHEXIA.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible] MD.

29c. License number: D46561

29d. Date signed *(Month, Day, Year)*: JAN 17, 2001.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Qadir 20311 Lappans Road Boonsboro, Maryland

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 26 2001

32. Registrar's Signature: [illegible] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item #15 .19a per FHG791 1/26/2001 EW

Certificate of Death

Reg. No. 2001 01875

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Louise Spriggs
2. Date of Death: Month Jan Day 20 Year 2001
3. Time of Death: 5-30 AM
4a. Facility Name (If not institution, give street and number): Millennium Nursing Home
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 220-07-9904
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 01 11 11
9. Birthplace (State or Foreign Country): M.D.

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: ☒ 1 Yes 2☐ No
10e. Street and Number: 2259 Madison Ave
10f. Zip Code: 21217
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ~~6th grade~~ N/A; College (1-4or 5+): na
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home Maker
16b. Kind of Business/Industry: Private Home

17. Father's Name (First, Middle, Last): Isaac Robinson
18. Mother's Name (First, Middle, Maiden Surname): Eleanor Ray

19a. Informant's Name/Relationship (Type, Print): ANNA ~~Annie~~ D. Higgins-Great Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1720 Judy Way, Edgewood, Md 21045

20a. Method of Disposition: ☒ 1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Voshell Mem. Gardens
Data: 1/16/01
20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeral Service Licensee: Gale March
22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cerebrovascular accident	6 month
Due to (or as a consequence of):	b. Congestive heart failure	years
Due to (or as a consequence of):	c. Renal failure	6 month
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Anantan M Maeem MD
29c. License number: D 15503
29d. Date signed (Month, Day, Year): Jan 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANANTHAM M MAEEM, 501 Dolphin st Balto MD 21217

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01876

PT. KNOWN AS EARL SIMMONS

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EARL L. SIMMONS SR.

2. Date of Death (Month, Day, Year): JANUARY 23 2001

3. Time of Death: 2:22 PM.

4a. Facility Name *(If not institution, give street and number)*: SINAI HOSPITAL OF BALTIMORE

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death:

Funeral Director

5. Social Security Number: 245 09 0082

6. Sex: 1 ☑ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 4/17/12

9. Birthplace *(State or Foreign Country)*: N.C.

Usual Residence of Decedent

10a. State: MD.

10b. County:

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 2540 LAURETTA AVE,

10f. Zip Code: 21223

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* AFRO AMERICAN

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 11; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: METAL SODER

16b. Kind of Business/Industry: UNITED IRON METAL

17. Father's Name *(First, Middle, Last)*: WILLIAM SIMMONS

18. Mother's Neme *(First, Middle, Maiden Surneme)*: NARCISSA CARTER

19a. Informent's Name/Relationship *(Type, Print)*: BETTY GREEN

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 3823 VICTORIA RD. RANDALLSTOWN, MD. 21244

20a. Method of Disposition: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other pleca)*: ARBUTUS PARK

Date: 01/27/01

20c. Location - City or Town, State: ARBUTUS, MD.

21. Signature of Funeral Service Licensee: CECIL A. ESTEP (Cecil A. Estep)

22. Name and Address of Facility: ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PL. BALTO. MD. 21217

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequenca ot):

b. CARDIOMYOPATHY (ISCHEMIC)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. HYPERTENSION

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the causa of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was en autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: D.O.

29c. License number: RES 000

29d. Date signed *(Month, Day, Year)*: JANUARY 23, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): MILTON ALVAREZ SINAI HOSPITAL OF BALTIMORE

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 26 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

01-0289-047
jhm
HAROLD B AMENDED ITEM#23a per M.E. G792 020801 SS
SPIKER amend item 23a,27 per me G791 1/31/01 yf

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01877

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Harold B. Spiker
2. Dete of Death Month: JANUARY Dey: 18, Year: 2001
3. Time of Death: 05:07 AM
4e Facility Name (If not institution, give street and number): UNIVERSITY HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-72-9993
6. Sex: 1☒ M 2☐ F
7. Age (In yrs, last birthday): 34 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Houra / Min.
8. Dete of Birth (Month, Day, Year): Aug. 20 1966
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10a. Street and Number: 1228 Cleveland Street
10f. Zip Code: 21230
10g. Citizen of What Country?: USA

11. Maritel Stetus: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired): Driver
16b. Kind of Business/Industry: Delivery

17. Father's Neme (First, Middle, Last): Harold Spiker
18. Mother's Neme (First, Middle, Maiden Surname): Geraldine Bathgate

19e. Informent's Name/Relationship (Type, Print): Al Bathgate (uncle)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 2915 Georgia Ave., Baltimore, MD. 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removei from Stete 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): New Cathederal Cemetery
Dete: Jan 24 2001
20c. Location - City or Town, Stata: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Russell Stallings
22. Name and Address of Feciility: Stallings Funeral Home, P.A. 3111 Mountain Rd., Pasadena, MD. 21122

Physician /Medical Examiner

23a. Pert I. Enter the diseeie, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respirelory errest, shock, or heart failure. List only one cause on each line. (Approximete Intervel Between Onset and Death)

Immediete Cause (Finel disease or condition resulting in death):
a. HYPERTENSIVE CARDIOVASCULAR DISEASE ~~HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE~~

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest
b.
Due to (or as a consequence of):
c.
Due to (or es a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contributa to the cauaa of death? 1☐ Yaa 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performed? 1☒ Yes 2☐ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medicel examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☒ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end piece, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: OCME
29d. Date signed (Month, Dey, Year): JANUARY 18, 2001

30. Nama and addreas of person who completed ceuse of death (Item 23a) (Type, Print): Henry G. Ruppel M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year): JAN 25 2001
32. Registrar's Signature: [signature]

ORIGINALS

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 01878

STINCHCOMB, CATHERINE

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CATHERINE STINCHCOMB
2. Date of Death (Month, Day, Year): JANUARY 25, 2001
3. Time of Death: 955 AM
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: AA COUNTY

Funeral Director

5. Social Security Number: 216.30.7361
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 69 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOVEMBER 1, 1931
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1☐ Yes 2☐ No XX
10a. Street and Number: 6 WENDOVER RD
10f. Zip Code: 21061
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME
17. Father's Name (First, Middle, Last): JOHN BLACKOWICZ
18. Mother's Name (First, Middle, Maiden Surname): PELAGIA SNYDER
19a. Informant's Name/Relationship (Type, Print): WILLIAM E. STINCHCOMB, JR.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6 WENDOVER RD. GLEN BURNIE, MD 21061
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): OUR LADY OF THE FIELDS PARISH CEMETERY
Date: 1.29.00
20c. Location - City or Town, State: MILLERSVILLE, MD
21. Signature of Funeral Service Licensee: K. GREGORY FINK
22. Name and Address of Facility: FINK FUNERAL HOME, P.A. 426 CRAIN HWY., S. GLEN BURNIE, MD 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):
b. CORONARY HEART DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
RHEUMATOID ARTHRITIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No
25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residance 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] M.D.
29c. License number: D0032138
29d. Date signed (Month, Day, Year): 01/25/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALEX HERTZMAN, MD 7845 OAKWOOD RD. #301 GLEN BURNIE, MD 21061

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: [signature]

ORIGINAL

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01879

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ethel M.E. Scheeler

2. Date of Death Month / Day / Year: January 21 2001

3. Time of Death: 12:20am

4a. Facility Name *(If not institution, give street and number)*: Hart Heritage Nursing Home

4b. City, Town, or Location of Death: Street

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 216 32 6909

6. Sex: 1☐ M 2☒ F (X)

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 3 1912

9. Birthplace *(State or Foreign Country)*: Baltimore Co., MD

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Cecilton

10d. Inside City Limits: 1☐ Yes 2☐ No (X)

10e. Street and Number: 6740 Augustine Herman Highway

10f. Zip Code: 21913

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed (X) 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No (X) If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No (X) *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Beautician

16b. Kind of Business/Industry: Self Employed

17. Father's Name *(First, Middle, Last)*: Henry J Betz

18. Mother's Name *(First, Middle, Maiden Surname)*: Martha Elizabeth Poetzsch

19a. Informant's Name/Relationship *(Type, Print)*: Michael Scheeler (Son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6740 Augustine Herman Highway PO Box 490 Cecilton, Maryland 21913

20a. Method of Disposition: 1☒ Burial (X) 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Zion Cemetery

Date: January 25, 2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Md. 21236

Physician /Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Progressive Dementia — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown (X)

24a. Was an autopsy performed? 1☐ Yes 2☒ No (X)

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No (X)

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Assisted Care Facility (X)

27. Manner of Death: 1☒ Natural (X) 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*: NA

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D39889

29d. Date signed *(Month, Day, Year)*: JAN. 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALFRED SCARLES 615 N. MACPHAIL RD BEL AIR, MD 21014

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 26 2001

32. Registrar's Signature: [signature] D. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01880

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: FRED SPAK

2. Dete of Death — Month: January; Dey: 23; Year: 2001

3. Time of Death: 10:08 AM

4a Facility Name *(If not institution, give street and number)*: Northwest Hospital Center

4b. City, Town, or Location of Death: Randallstown, Md

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 289-30-6795

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Mar. 6, 1930

9. Birthplace *(State or Foreign Country)*: Poland

Usual Residence of Decedent

10a. Stete: MD

10b. County: BALTIMORE

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1500 BEDFORD AVENUE #515

10f. Zip Code: 21208

10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elemantery/Secondery (0-12): 6; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: PROPRIETOR

16b. Kind of Business/Industry: FURNITURE

17. Father's Neme *(First, Middle, Last)*: SAMUEL SPAK

18. Mother's Name *(First, Middle, Maiden Surname)*: LENA EISEKOWITZ

19a. Informent's Neme/Relationship *(Type, Print)*: BARBARA SPAK / WIFE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1500 BEDFORD AVENUE #515 - BALTIMORE, MD 21208

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Plece of Disposition *(Name of cemetery, crematory or other place)*: BALTIMORE HEBREW CEMETERY

Dete: 1/25/01

20c. Location - City or Town, Stete: REISTERSTOWN, MD

21. Signature of Funeral Service Licensee: Scott M Cuttler

22. Name end Address of Fecility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or raspiratory errest, shock, or haart failure. List only one causa on aach lina.

Approximate Interval Between Onset and Deeth

Immediete Ceuse (Finel disease or condition resulting in deeth):

a. myocardial ischemia

Due to (or es e consequence of):

b. congestive heart failure

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Lest

Due to (or as a consequence of):

c. diabetes mellitus

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Plece of Deeth *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [✓] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Death: 1 [✓] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Erica Tobin Muldrow, MD

29c. License number: D0052760

29d. Date signed *(Month, Day, Year)*: January 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 5401 old Court Road Randallstown, Maryland 21133

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001

32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01881

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Blanche A. Stanford

2. Dete of Deeth: Month Jan. Dey 19, Year 2001

3. Time of Death: 1:15am

4a. Facility Nema (If not institution, give straet and number): Frankford Nursing Home

4b. City, Town, or Location of Deeth: Baltimore

4c. County of Deeth: NA

Funeral Director

5. Social Security Number: 215-16-5845

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. lest birthday): 87 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Year): 04-26-13

9. Birthpleca (Stete or Foreign Country): MD

Usuel Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2808 E. Federal Street

10f. Zip Code: 21213

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yas 2☐ No Specify:

14. Reca - Amarican Indlen, Black, Whita, atc. Specify: Black

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12): 8th Grade; College (1-4or 5+): NA

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Domestic

16b. Kind of Business/Industry: other people homes

17. Fether's Neme (First, Middle, Last): George Stanford

18. Mother's Name (First, Middle, Maiden Surneme): Blanche Thompson

19e. Informant's Neme/Reletionship (Type, Print): Doris Garnes

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 2808 E. Federal Street Baltimore, Maryland 21213

20e. Method of Disposition: 1☒ Burlel 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Dulaney Valley Cem.

Dete: 01-26-01

20c. Locetion - City or Town, Stete: Dulaney Valley, MD

21. Signeture of Funeral Service Licensee: ▶ Gladys Warner

22. Name and Address of Fecility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complications that causad tha deeth. Do not anter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on aach line.

Approximata Intervel Between Onset end Deeth

Immediate Cause (Finel diseese or condition resulting in deeth): e. METASTATIC SQUAMOUS CELL CARCINOMA SKIN

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last

b.

Dua to (or es e consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yas 2☐ No 3☐ Probably 4☑ Unknown

24e. Wes an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

28. Piece of Deeth (Check only one): Hospital: 1☐ Inpatiant 2☐ ER/Outpetient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Deeth: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end placa, and dua to tha cause(s) end menner steted.

29b. Signetura and titie of certifier: ▶ compensation MD

29c. License number: D16619

29d. Data signed (Month, Day, Year): 1/25/01

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print): C. VERGARA-SOARES 5009 FRANKFORD AVE. BALTIMORE, MD. 21206

State Registrar

31. Date filed (Month, Dey, Yeer): JAN 26 2001

32. Registrar's Signeture: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01882

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Theresa Smallwood

2. Date of Death (Month, Day, Year): JANUARY 20, 2001

3. Time of Death: 05:52 AM

4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: NA

Funeral Director

5. Social Security Number: 214-88-6741

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 36 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 05-02-64

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1030 Comet Street

10f. Zip Code: Baltimore

10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th Grade

College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Crossing Guard

16b. Kind of Business/Industry: Baltimore City

17. Father's Name (First, Middle, Last): Johnie Smallwood

18. Mother's Name (First, Middle, Maiden Surname): Mae Washington

19a. Informant's Name/Relationship (Type, Print): Mae Smallwood

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1030 Comet Street Baltimore, Maryland 21202

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): King Mem. Pk. Cemetery

Date: 01-27-2001

20c. Location - City or Town, State: Randallstown MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory insult — one week

Due to (or as a consequence of):

b. Pneumonia — one week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Acute Respiratory Distress Syndrome — one week

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ron Elfenbein - M.D.

29c. License number: RES-000

29d. Date signed (Month, Day, Year): 01/20/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ron Elfenbein, MD Johns Hopkins Hospital - 600 N. Wolfe St. Baltimore MD 21287

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

CS
01-0368-005
JERRY THOMPSON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS# 23a,ptII, & 27 per ME G792 022701 SS

Certificate of Death

Reg. No 2001 01883

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jerry L. Thompson
2. Date of Death (Month, Day, Yaer): January 22, 2001
3. Time of Death: 14:55
4a. Facility Name (If not institution, give street and number): Northwest Hospital Center
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 243-21-5497
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 31 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 2, 1969
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3923 Boarman Ave.
10f. Zip Code: 21215
10g. Citizan of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Merried 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:
14. Race - American Indien, Bieck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 8
16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): Waste Water Technician
16b. Kind of Business/Industry: Balto. City

17. Father's Neme (First, Middle, Last): Charles Parks
18. Mother's Neme (First, Middle, Maiden Surname): Chawanta Langston

19a. Informent's Neme/Reletionship (Type, Print): (mother) Mrs. Chawanta Langston
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3923 Boarman Ave. Balto. Md. 21215

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Piece of Disposition (Name of cematery, crematory or other placa): Elmwood Cemetery
Dete: 1/31/2001
20c. Location - City or Town, State: Goldsboro, North Cardina

21. Signature of Funerel Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death

Immediata Cause (Finel disease or condition resulting in death): a. CARDIAC ARRHYTHMIA AND ACUTE PULMONARY EDEMA ASSOCIATED WITH CARDIAC HYPERTROPHY AND BIVENTRICULAR DILATION STATUS POST UVULOPALATOPHARYNGOPLASTY AND TONSILLECTOMY

Due to (or es a consequence ot):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last: b.

Due to (or es a consequence of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: OBESITY

23b. Did tobacco use contribute to the causes of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was en eutopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to compiation of cause of death? 1 [X] Yas 2 [ ] No

25. Wes case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Piece of Deeth (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Couid not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end placa, end due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated.

29b. Signature and title of certifier: Dennis J Clutom
29c. License number: OCME
29d. Data signed (Month, Day, Year): January 23, 2001

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chutom 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: Donna B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01884

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROSE L TOMLIN
2. Date of Death (Month, Day, Year): JAN 24 2001
3. Time of Death: 9:45am

4a. Facility Name *(If not institution, give street and number)*: 817 MArtin Road
4b. City, Town, or Location of Death: Essex
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-14-9016
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec.14,1923
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 817 Martin Road
10f. Zip Code: 21221
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10th | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Wire & Soder Line
16b. Kind of Business/Industry: Westinghouse

17. Father's Name *(First, Middle, Last)*: Angelo Galantino
18. Mother's Name *(First, Middle, Maiden Surname)*: Alice Lenardo

19a. Informant's Name/Relationship *(Type, Print)*: James H Tomlin /husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 817 MArtin Road Baltimore MD 21221

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holly Hill Cemetery | Date: 1/26/01
20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: ▶ R. Terry Connelly
22. Name and Address of Facility: Connelly Funeral Home of Essex 300 MAce AVe. Baltimore MD. 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximate interval Between Onset and Death
Immediate Ceuse (Flnai disease or condition resulting In death) a.	Pneumonia	1 week
Due to (or as a consequence of):		
Sequentially list conditions, if any, leeding to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting In death) Last b.	Cerebravascular Disease	4 years
Due to (or as a consequenca of):		
c.	Dementia	3 years
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting In the underlying cause given in Part I.

23b. Did tobacco use contributa to the causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyaician**: To the best of my knowledge, deeth occurred at the tima, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Lois Anne Tolley
29c. License number: D0052928
29d. Date signed *(Month, Day, Year)*: 1/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MaryAnne Nidiry 1792 Merritt Blvd Baltimore Md 21222

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 26 2001
32. Registrar's Signature: ▶ Patricia A. Sparks

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

IN

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01885

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Brianna Mitchell Taylor
2. Date of Death (Month, Day, Year): January 21, 2001
3. Time of Death: 10:15 a.
4a. Facility Name (If not institution, give street and number): Sinai Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: N/A
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min. 5
8. Date of Birth (Month, Day, Year): January 21, 2001
9. Birthplace (State or Foreign Country): USA

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5604 Cedonia Avenue
10f. Zip Code: 21206
10g. Citizen of What Country?: USA

11. Meritel Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No
If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bleck, White, etc.
Specify: Black

15. Decedent'a Eduestion (Specify only highest grade completed)
Elementary/Secondary (0-12): Infant
College (1-4or 5+): Infant
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Infant
16b. Kind of Busineas/Industry: Infant

17. Father's Name (First, Middle, Last): Timothy Taylor
18. Mother's Name (First, Middle, Maiden Surname): Ariana Mitchell

19a. Informent'a Name/Relationship (Type, Print): Ariana Mitchell
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5604 Cedonia Avenue Baltimore, Maryland 21206

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Cemetery
Date: 01-26-2001
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name end Address of Facility: WM.C.March FH 1101 E. North Avenue Baltimore, Maryland 21202

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. (Approximate Interval Between Onset and Deeth)

Immediate Ceuse (Final disease or condition resulting in deeth)
a. Extreme prematurity
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Cause (Disease or Injury that initiated eventa resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one)
Hospital: 1☒ Inpetient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): N/A
28b. Time of Injury: N/A M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Deecribe how injury occurred: N/A
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify): N/A
28f. Location (Street and Number or Rural Route Number, City or Town, State): N/A

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and mannar as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: Denise Walinsky MD
29c. License number: D53005
29d. Date signed (Month, Day, Year): 1/21/01

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Denise Walinsky, M.D. Sinai Hospital, 2401 W. Belvedere Ave. Baltimore, MD 21215

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #13 PER F.H. G792 2-7-01 WR.

Certificate of Death

Reg. No. 2001 01886

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cleo Wade

2. Date of Death: Month January Day 20 Year 2001

3. Time of Death: 0915 AM

4a. Facility Name (If not institution, give street and number): Baltimore Veteran's Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-46-6975

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 53 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV. 18, 1947

9. Birthplace (State or Foreign Country): N.C.

Usual Residence of Decedent

10a. State: Md

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1616 OLIVER ST.

10f. Zip Code: 21213

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Inspector

16b. Kind of Business/Industry: housing

17. Father's Name (First, Middle, Last): CARTHELL WADE

18. Mother's Name (First, Middle, Maiden Surname): MYRTIE McCULLUM

19a. Informant's Name/Relationship (Type, Print): TAKEIA WADE (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 630

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST VET CEM.

Date: 1-30-01

20c. Location - City or Town, State: BALTO. MD.

21. Signature of Funeral Service Licensee: Carlton C. Douglass

22. Name and Address of Facility: Carlton C. Douglass Funeral Service P.A. 1701 McCulloh St. Balto. Md. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Lung Cancer (Non-Small Cell)

Due to (or as a consequence of): b. Chronic Lymphocytic Leukemia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: List MD

29c. License number: P14683

29d. Date signed (Month, Day, Year): January 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Patrick List - 10 N Greene St

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001

32. Registrar's Signature: Denise B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 2 should be detached for use as the burial-transit

#13

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01887

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lewis Henry Williams

2. Date of Death Month / Day / Year: JANUARY 25 2001

3. Time of Death: 4:50 A.M.

4a. Facility Name *(If not institution, give street and number)*: FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death: ROSEDALE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 233-12-7761

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 22, 1910

9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3206 Echodale Avenue

10f. Zip Code: 21214

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Carpenter

16b. Kind of Business/Industry: Local Union

17. Father's Name *(First, Middle, Last)*: Albert Williams

18. Mother's Name *(First, Middle, Maiden Surname)*: Clara Light

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Helen F. Williams / wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3206 Echodale Avenue Baltimore, Md. 21214

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parkwood Cemetery

Date: 1/29/2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Michael E. Canapp

22. Name and Address of Facility: LEONARD J. RUCK, INC. 5305 Harford Road Baltimore, MD 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HYPOXIA, HYPERCAPNIA

Due to (or as a consequence of):

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. LEFT LOWER LOBE PNEUMONIA

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERCHOLESTEREMIA

HYPERTENSION

PERIPHERAL VASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D 203356

29d. Date signed *(Month, Day, Year)*: 1/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TOWANNA FONTENOT, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 26 2001

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

LEWIS, WILLIAMS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01888

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy Margaret Webb
2. Date of Death: Month January Day 24 Year 2001
3. Time of Death: 12:15 P.M.
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN Burnie
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 212-20-7522
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb 6 1923
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7754 West Drive
10f. Zip Code: 21060
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): manufacturing
16b. Kind of Business/Industry: American Can

17. Father's Name (First, Middle, Last): William T. Blades
18. Mother's Name (First, Middle, Maiden Surname): Margaret Deal

19a. Informant's Name/Relationship (Type, Print): Gail Brousseau / daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 491 Saltoun Ave. Odenton, MD 21113

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Meadowridge Cemetery
Date: 1/27/01
20c. Location - City or Town, State: Elkridge, Md

21. Signature of Funeral Service Licensee: ▶ Mitchell Stallings
22. Name and Address of Facility: Stallings Funeral Home P.A. 3111 Mountain Road Pasadena, MD 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SEPTICEMIA	4 days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: D43977
29d. Date signed (Month, Day, Year): January 24 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ayoka Bruning 301 Hospital Drive, Glen Burnie, MD 21061.

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature: ▶ Barbara G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Webb Dorothy

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: # 22 PER F.H. G791 1-26-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01889

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day	Year	3. Time of Death
Willie	White, Jr.	Jan.	22,	01	23:34

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
501 E. Preston Street Apt. #111	Baltimore	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-38-9270	1☐M 2☐F XX	70 Yrs.					Nov. 24, 1930	South Carolina

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland		Baltimore City	XX Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
501 E. Preston Street Apt. 111	21202	USA

11. Meritel Stetus	12. Wes Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specity Cuben, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2XX No If Yes, Give Yeer or Detes:	1☐ Yes 2XX No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6		Brick Mason	Construction

17. Father's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
Willie White, Sr.	Mamie Richardson

19e. Informent's Neme/Reletionship (Type, Print)	19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Benjamine J. White (son)	5435 Radecke Ave. Baltimore, Maryland 21206

20e. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)	Dulaney Valley Memorial Gdn 2001	Jan. 29	Timonium, Maryland

21. Signature of Funerel Service Licensee
▶ Brian T. Chisholm

22. Name end Address of Feciility
BRIAN T. CHISHOLM FUNERAL SERVICES OF ~~Baltimore, Maryland 21202~~
DULANEY VALLEY, P.A. 200 E. PADONIA RD. TIMONIUM, MD.
~~WM.C.March FH~~ 1101 E. North Avenue

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

28a. Part I. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heert failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Finel disease or condition resulting in deeth)	a. Congestive heart failure	2 wks
	Due to (or es e consequenca of):	
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hypertension	years
	Due to (or as e consequenca of):	
	c. Obesity	years
	Due to (or es e consequenca of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes an autopsy performed?	24b. Were autopsy findings svailable prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical exeminer?	26. Plece of Deeth (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) and menner es stated.
2☐ **Medical Examiner:** On the basis of exemination and/or investigetion, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner stated.

29b. Signeture and title of certifier	29c. License number	29d. Dete signed (Month, Dey, Year)
▶ Amatun N Naeem MD	D15503	Jan 24, 01

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print)
AMATUN N NAEEM, 501 Dolphin st, Balto, MD 21217

State Registrar

31. Date filed (Month, Dey, Yeer)	32. Registrar's Signeture
JAN 26 2001	▶ Jenna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01890

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Toney M. Watson

2. Date of Death (Month, Day, Year): January 18, 2001

3. Time of Death: 6:05 am

4a. Facility Name (If not institution, give street and number): 2902 W. Coldspring Lane

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-34-5876

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 4, 1933

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2902 W. Coldspring Lane

10f. Zip Code: 21215

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Afro-American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesperson

16b. Kind of Business/Industry: Retail

17. Father's Name (First, Middle, Last): Toney Powell

18. Mother's Name (First, Middle, Maiden Surname): Ida Scott

19a. Informant's Name/Relationship (Type, Print): (son) Mr. Charles Scruggs

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2420 Woodbrook Ave. Balto. Md. 21217

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion

Date: 1/25/2001

20c. Location - City or Town, State: Lansdowne, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. ASCVD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. DM Type 2

Due to (or as a consequence of):
c. Hypertension

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Salome Hawkins

29c. License number: H 46961

29d. Date signed (Month, Day, Year): 1/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SALOME HAWKINS, D.O. Sinai Community Care 5101 Lanier Ave Baltimore MD 21215

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001

32. Registrar's Signature: Geneva D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01891

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Estella Williams

2. Deta of Deeth — Month: January; Dey: 20; Yaer: 2001

3. Time of Death: 5:16 PM

4a. Facility Nama (If not institution, giva street and number): Genesis Eldercare

4b. City, Town, or Location of Deeth: Randallstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-76-1932

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthdey): 52 Yrs.

If Under 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yaar): Nov. 14, 1948

9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1520 Rawlings Well Rd.

10f. Zip Code: 21228

10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1☒ Nevar Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxicen, Puerto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: Afro-American

15. Decedent's Educetion (Specify only highest grade completed): Elementary/Secondery (0-12): N/A; Collega (1-4or 5+): N/A

16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired): N/A

16b. Kind of Business/Industry: N/A

17. Fether's Name (First, Middla, Last): Warner Williams

18. Mother's Neme (First, Middle, Maiden Sumame): Carolyn Reddix

19a. Informant's Name/Reletionship (Type, Print): Mr. Ollen Douglass (Caretaker)

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 611 Park Ave. Balto. Md. 21201

20a. Method of Disposition: 1☒ Buriel 2☐ Crametion 3☐ Ramovel from Steta 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other place): Mt. Zion

Data: 1/25/2001

20c. Location - City or Town, State: Lansdowne, Md.

21. Signature of Funerel Service Licensee: Joseph L. Russ

22. Nama end Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heert feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Finel diseese or condition resulting in death): a. Pneumonia — Few days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Lest:

b.

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residance 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end piece, and due to the cause(s) and menner steted.

29b. Signature end titla of certifiar

29c. Licensa number: D60491

29d. Date signed (Month, Dey, Year): JANUARY 23 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): 800 N Hammonds Ferry Rd. Linthicum Md. 21090

State Registrar

31. Dete filed (Month, Day, Year): JAN 26 2001

32. Registrar's Signetura: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-0402-510
CJ
Roy David Yarbor

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS# 23a,27,&28a-f per ME G792 021401 SS

Certificate of Death

Reg. No. 2001 01892

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Roy David Yarbor

2. Date of Death: Month January, Day 24, Year 2001

3. Time of Death: 06:45 P.M.

4a. Facility Name (If not institution, give street and number): 1907 Griffis Avenue

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-70-9578

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 43 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): June 28, 1957

9. Birthplace (State or Foreign Country): TN

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1907 Griffis Avenue

10f. Zip Code: 21230

10g. Citizen of What Country? United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4; College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Construction Worker

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Roy H. Yarbor

18. Mother's Name (First, Middle, Meiden Surname): Rose B. Greene

19a. Informant's Name/Reletionship (Type, Print): Rose B. Yarbor / Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1907 Griffis Avenue, Baltimore Maryland 21230

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Meadowridge Memorial Park Jan. | Date: 27, 2001

20c. Location - City or Town, State: Baltimore Maryland

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.

22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SUBDURAL HEMATOMA

Due to (or es a consequence ot):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco uee contribute to the cause of death? 1 [ ] Yee 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year): unknown

28b. Time of Injury: unknown M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how Injury occurred: subject fell

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): unknown

28f. Location (Street and Number or Rural Route Number, City or Town, State): unknown

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): January 25, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): J. AARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01893

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Judith Allen
2. Date of Death (Month, Day, Year): Jan 8, 2001
3. Time of Death: 3:30 A.M.
4a. Facility Name (If not institution, give street and number): 6005 Cloverleaf Avenue
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 173 36 5489
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 53 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 2, 1947
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Clinton
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 6005 Cloverleaf Ave
10f. Zip Code: 20735
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Executive Secretary
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): John Francis Barrish, Jr.
18. Mother's Name (First, Middle, Maiden Surname): Genevieve Chesslo

19a. Informant's Name/Relationship (Type, Print): Michelle L. Mitchell (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3038 Queensberry Drive, Huntingtown, Maryland 20639

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Evergreen Memorial Park — Jan 11, 2001
20c. Location - City or Town, State: Point Marion, PA

21. Signature of Funeral Service Licensee: ▶ Charles L. Bélanger
22. Name and Address of Facility: Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. pulmonary fibrosis Breast cancer	2 years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner stated.

29b. Signature and title of certifier: ▶ D. Haidak
29c. License number: D-17605
29d. Date signed (Month, Day, Year): 01/08/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David J. Haidak, M.D. 8926 Woodyard Rd. # 201 Clinton, Md. 20735

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001
32. Registrar's Signature: Lynn P. Spicer

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 01894

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FREDERICK AWOTWI

2. Date of Death Month: January Day: 3 Year: 2001

3. Time of Death: 4:05 PM

4a. Facility Name (If not institution, give street and number): Malcom Grow Medical Center A.A.F.B.

4b. City, Town, or Location of Death:

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 226 65 4889

6. Sex: 1 ☐ M 2 ☐ F — XX

7. Age (In yrs. last birthday): 53 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 4, 1947

9. Birthplace (State or Foreign Country): West Africa

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Camp Springs

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 6281 Maxwell Drive Apt 1

10f. Zip Code: 20746

10g. Citizen of What Country?: Ghana Citizen

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4 or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Parking Attendant

16b. Kind of Business/Industry: Central Parking

17. Father's Name (First, Middle, Last): Kwabena Awotwi

18. Mother's Name (First, Middle, Maiden Surname): Adjowa Taamadwu

19a. Informant's Name/Relationship (Type, Print): Sidney Awotwi (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 29 Wellspring Bear, Deleware, 19701

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Resurrection Cemetery Date: Jan 13, 2001

20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hepatocellular CA — Approximate Interval: 4 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D24532

29d. Date signed (Month, Day, Year): 1/08/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID A VAN ELLS, MD 22 South Green Street 21201 Baltimore, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001

32. Registrar's Signature: B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(10)

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend # 31.PGC 1-12-01 cr

Certificate of Death

Reg. No. 2001 01895

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Maggie Mae Adams

2. Date of Death: Month January Day 5, Year 2001

3. Time of Death: 12:20 AM

4a. Facility Name (If not institution, give street and number): Doctor's Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: P.G.

Funeral Director

5. Social Security Number: 428-38-7644

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12/30/1924

9. Birthplace (State or Foreign Country): Mississippi

Usual Residence of Decedent

10a. State: Md

10b. County: P.G.

10c. City, Town or Location: Springdale

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 9000 Ardmore Road

10f. Zip Code: 20774

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Henry Drummond

18. Mother's Name (First, Middle, Maiden Surname): Annie Lou Barnes

19a. Informant's Name/Relationship (Type, Print): Melvin Adams /son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4002 Oaklawn Rd. Ft. Washington, Md. 20744

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Memorial Park | Date: 1/13/01

20c. Location - City or Town, State: Landover, Md.

21. Signature of Funeral Service Licensee: Janice Edwards

22. Name and Address of Facility: Hodges and Edwards, 3910 Silver Hill Rd. Suitland, MD. 20746

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arrythmia

Due to (or as a consequence of): b. Hypoxia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: Due to (or as a consequence of): c. Asthma

Due to (or as a consequence of): d. Chronic obstructive Pulmonary disease

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jeffrey S. Howe MD

29c. Licensa number: D33983

29d. Date signed (Month, Day, Year): 1/5/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeffrey S. Howe MD 8118 Good Luck Rd Lanham, md 20706

State Registrar

31. Date filed (Month, Day, Year): 1/5/2001 JAN 12 2001

32. Registrar's Signature: Geneva G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Maggie Mae ADAMS.

SR

10

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01896

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Louise Eisler Burke
2. Date of Death (Month, Day, Year): January 4, 2001
3. Time of Death: 3:30 pm
4a. Facility Name *(If not institution, give street and number)*: 2509 Parkway
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 215-44-7928
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 13, 1919
9. Birthplace *(State or Foreign Country)*: Germany

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Cheverly
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2509 Parkway
10f. Zip Code: 20785
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary
16b. Kind of Business/Industry: Government Printing Office

17. Father's Name *(First, Middle, Last)*: Matthew Eisler
18. Mother's Name *(First, Middle, Maiden Surname)*: Rosa Enzle

19a. Informant's Name/Relationship *(Type, Print)*: Mary Bienvenue - Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4716 Davenport Street, N.W., Washington, DC 20016

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mount Olivet Cemetery | Date: 01/08/01
20c. Location - City or Town, State: Wshington, DC

21. Signature of Funeral Service Licensee: Allen Smith
22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Breast Carcinoma — 1 Year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Arteriosclerotic Cardiovascular Disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
26d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of Certifier: [signature] MD
29c. License number: D08754
29d. Date signed *(Month, Day, Year)*: January 5, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Thomas A. Bensinger, M.D. 7525 Greenway Center Drive #205, Greenbelt, MD 20770

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 08 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01897

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
ESTHER	BALLENGER	January 2, 2001	5:07 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Prince George's Hospital Center	Cheverly	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
245-10-0929	1☐ M 2☒ F	82 Yrs.			March 5, 1918	South Carolina

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
D.C.		Washington	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4427 Hunt Place, N.E.	20019	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th Grade		Housewife	None

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
David Faucett	Carrie Simpson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Tyran A. Ballenger (Son)	4428 Hunt Place, N.E. Washington, D.C. 20019

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	National Harmony Memorial Park	1/9/2001	Landover, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Janet C. Anderson	ROLLINS FUNERAL HOME, INC. 4339 Hunt Place, N.E. Washington, D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiogenic and hypovalemic shock	hr.
Due to (or as a consequence of):	b. aspiration pneumonia	hr.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Acute myocardial infarction	days
Due to (or as a consequence of):	d. Diffuse coronary atherosclerosis	years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, end stage renal disease
anaemia, cerebrovascular accident
by History, poss. Sepsis

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ RP Rastogi MD	D24720	1/02/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAVINDER K. RASTOGI MD
6132 Landover Road, Cheverly MD 20785

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 08 2001	[signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(4)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01898

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas Fraser Brownlee

2. Date of Death (Month, Day, Year): January 6, 2001

3. Time of Death: 7:40AM

4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 542-50-7151

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 55 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 10, 1945

9. Birthplace (State or Foreign Country): Longview Washington

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Clinton

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 9014 Cameron Ct.

10f. Zip Code: 20735

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Yaar or Dates: 1965-1987

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Educetion (Specify only highast grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired): Contracting Officer IRS

16b. Kind of Business/Industry: U.S. Government

17. Father's Nama (First, Middle, Last): Harold Bronwlee

18. Mother's Name (First, Middle, Maiden Surnama): Harriett Saum

19a. Informant's Name/Relationship (Type, Print): Phyllis A. Brownlee (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 9014 Cameron Court Clinton, Maryland 20735

20a. Method of Disposition: 1☒Burial 2☐Cramation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Nama of cematary, cramatory or othar place): St. Brendans Catholic Ch. Cem. Date: January 11, 2001

20c. Location - City or Town, State: Elkins West Virginia

21. Signature of Funeral Service Licensee: ▶ Charles L. Bilanger

22. Name and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinotn, MD20735

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia with sepsis — 2days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Carcinoma of Urinary Bladder

Due to (or as a consequence of):

c.

Due fo (or as a consequance of):

d.

Part fI. **Other significant conditfons** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contributa to the causa of death? 1☐Yas 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No N/A

25. Was case refarred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only ona): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D46478

29d. Date signed (Month, Day, Year): 1-7-01

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Suresh A. Patel MD 7501 Sunatts Rel #307. Clinton. MD20735

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001

32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Brownlee, Thomas 1/6/01 CR @ 7:40 am

20 IVa

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01899

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Oscar L. Bagley
2. Date of Death: Month January Day 5 Year 2001
3. Time of Death: 12:50 AM
4a. Facility Name (If not institution, give street and number): Prince George's Hospital
4b. City, Town, or Location of Death: Cheverly, MD
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-42-2727
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 66 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): January 10, 1934
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Glenarden
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7905 Polk Street
10f. Zip Coda: 20706
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4Yrs; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Budget Analyst
16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Earnest Bagley
18. Mother's Name (First, Middle, Maiden Surname): Leora Jefferson

19a. Informant's Name/Relationship (Type, Print): Nancy A. Bagley/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7905 Polk St. Glenarden, MD 20706

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans Cemetery
Date: 01/11/01
20c. Location - City or Town, State: Cheltenham, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: J.B. Jenkins Funeral HOme 7474 Landover Rd. Landover, MD 20785

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease — 4 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia; Dysphagia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D01852
29d. Date signed (Month, Day, Year): January 5 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul A DeVore MD 4203 Duvernay Rd Hyattsville MD 20781

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01900

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HATTIE BROWNE

2. Date of Death Month: 01 Day: 03 Year: 2001

3. Time of Death: 4:30 PM

4a. Facility Name *(If not institution, give street and number)*: Southern Maryland Hospital

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-36-5224

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 1, 1931

9. Birthplace *(State or Foreign Country)*: Harrisburg, PA

Usual Residence of Decedent

10a. State: District of Columbia

10b. County:

10c. City, Town or Location: Washington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 741 Congress Street, S.E.

10f. Zip Code: 20032

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* African-American

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12):

College (1-4or 5+): 3 years

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Personnel Specialist

16b. Kind of Business/Industry: Government

17. Father's Name *(First, Middle, Last)*: Henry Flippen

18. Mother's Name *(First, Middle, Maiden Surname)*: Catherine Ancrum

19a. Informant's Name/Relationship *(Type, Print)*: Gregory E. Browne - Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 17214 Birch Leaf Terrace Bowie, MD 20716

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Harmony Mem. Park

Date: 1/12/2001

20c. Location - City or Town, State: Landover, MD

21. Signature of Funeral Service Licensee: John T. Stewart, III

22. Name and Address of Facility: Stewart Funeral Home, Inc. 4001 Benning Road, N.E. Washington, D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. GI Bleed

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Renal Failure.

Due to (or as a consequence of):

c. HTN -

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*

Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D 41580

29d. Date signed *(Month, Day, Year)*: January 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Scott Kelso 7503 Surratts Road, Clinton, MD 20735

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 09 2001

32. Registrar's Signature: Brenda E. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

(10)

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ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01901

CLARA G. BASSETT

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CLARA G. BASSETT
2. Date of Death Month / Day / Year: Jan. 6 2001
3. Time of Death: 1:55 AM
4a. Facility Name *(If not institution, give street and number)*: St. Agnes Rehabilitation & Nursing Center
4b. City, Town, or Location of Death: Ellicott City
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 229-12-2244
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 25, 1922
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4021 Jumper Hill Lane
10f. Zip Code: 21042
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* white
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner
16b. Kind of Business/Industry: wholesale
17. Father's Name *(First, Middle, Last)*: unobtainable
18. Mother's Name *(First, Middle, Maiden Surname)*: Agnes Winfrey
19a. Informant's Name/Relationship *(Type, Print)*: Stephen R. Bassett / Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 4021 Jumper Hill Lane Ellicott City, MD 21042
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Placa of Disposition *(Name of cemetery, crematory or other place)*: Ft. Lincoln Cemetery Date: January 9, 2001
20c. Location - City or Town, Stete: Brentwood, MD
21. Signature of Funeral Service Licensee: Shawn E Miller
22. Name and Address of Facility: Ft. Lincoln Funeral Home, 3401 Bladensburg Rd. Brentwood, MD 20722

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE	YEARS
	Due to (or as a consequence of):	
Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ALZHEIMER'S DISEASE

23b. Did tobacco use contribute to the ceuse of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James P. Richardson MD
29c. License number: D 27394
29d. Date signed *(Month, Dey, Year)*: 1/8/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMES P. RICHARDSON MD 700 DULANE ROAD, TOWSON, MD 21286

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 09 2001
32. Registrar's Signature: Regina B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01902

Physician /Medical Examiner

(1) Decedent's Name (First, Middle, Last): James Edward Blakeney

2. Date of Death (Month, Day, Year): January 8 01

3. Time of Death: 4:15 A.M.

4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: not available

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): Yrs. | If Under 1 Year: Months | Days: 21 | If Under 24 Hrs.: Hours | Min.

8. Date of Birth (Month, Day, Year): December 19, 2000

9. Birthplace (State or Foreign Country): Baltimore, MD

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Clinton

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 7404 Serenade Circle

10f. Zip Code: 20735

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): never employed

16b. Kind of Business/Industry: n/a

17. Father's Name (First, Middle, Last): James Edward Blakeney III

18. Mother's Name (First, Middle, Maiden Surname): Celeste Marie Scotton

19e. Informant's Name/Relationship (Type, Print): James Blakeney III/Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7404 Serenade Circle, Clinton, MD 20735

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Resurrection Cemetery

Date: 1/10/2001

20c. Location - City or Town, State: Clinton, MD

21. Signature of Funeral Service Licensee: Sonja Montgomery-Cheatham

22. Name and Address of Facility: CEDAR HILL FUNERAL HOME, INC. 4111 Pennsylvania Ave., Suitland, MD 20746

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Necrotizing enterocolitis — 12 hrs.

Due to (or as a consequence of):

b. Prematurity — 19 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Respiratory distress syndrome

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sharon Lee Marbau MD

29c. License number: D32568

29d. Date signed (Month, Day, Year): January 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sharon Lee Marbau, M.D. Johns Hopkins Hospital

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001

32. Registrar's Signature: Bessie P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01903

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Pearl Bennett

2. Date of Death: Month: January Day: 7 Year: 2001

3. Time of Death: 1:20PM

4a. Facility Name (If not institution, give street and number): St. Thomas More Nursing Home

4b. City, Town, or Location of Death: Hyattsville

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-44-4083

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months: Days:

If Under 24 Hrs.: Hours: Min.:

8. Date of Birth (Month, Day, Year): Sept. 1, 1912

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: District of Columbia

10b. County:

10c. City, Town or Location: Washington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2500 Branch Ave., S.E.

10f. Zip Code: 20020

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Substitute Teacher

16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Alfred D. Thompson

18. Mother's Name (First, Middle, Maiden Surname): Hannah Marshburn

19a. Informant's Name/Relationship (Type, Print): Rosalyn S. Thompson - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2500 Branch Ave., S.E. Wash., D.C. 20020

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Park Lawn Cemetery

Date: 1/12/2001

20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service Licensee: John T. Stewart, III

22. Name and Address of Facility: Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular disease

Due to (or as a consequence of):

b. Hypertension

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Parkinson disease

Alzheimers Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residance 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Meer Said Zaveri MD

29c. License number: D22708

29d. Date signed (Month, Day, Year): 01/08/01

30. Name and address of person who completed cause of death (item 23a) (Type, Print): Meer Said Zaveri MD 1328 Southern Ave SE #307 Washington D.C. 20032

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001

32. Registrar's Signature: Regina P. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01904

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELEANOR D. BENSON
2. Date of Death (Month, Day, Year): JAN. 8, 2001
3. Time of Death: 7:15 AM
4e. Facility Name (If not institution, give street and number): NATIONAL LUTHERAN HOME
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 213-38-0874
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 22, 1908
9. Birthplace (State or Foreign Country): WASH., DC

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: ROCKVILLE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 9701- VEIRS DR.,
10f. Zip Code: 20850
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TELEPHONE SWITCHBOARD
16b. Kind of Business/Industry: ADMINISTRATIVE

17. Father's Name (First, Middle, Last): WILLIS DAVIS
18. Mother's Name (First, Middle, Maiden Surname): AMELIA HORNE

19a. Informant's Name/Relationship (Type, Print): RALPH BENSON- SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11403-FARMLAND DR., ROCKVILLE, MD.

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): METROPOLITAN CREMATORY | Date: 1/10
20c. Location - City or Town, State: ALEXANDRIA, VA.

21. Signature of Funeral Service Licensee: ▶ Wm. Hysong
22. Name and Address of Facility: HYSONG CO., INC. 6510- 16th ST., NW, WASH., DC

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. End Stage Alzheimers Dementia — 6 years
Due to (or as a consequence of):
b. Cerebral vascular accident — 10 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus
Congestive Heart failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Charles W. Kenerson
29c. License number: D21726
29d. Date signed (Month, Day, Year): January 8, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. CHARLES KARESH. 9701- VEIRS DR. ROCKVILLE, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001
32. Registrar's Signature: Geneva G. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01905

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eugene Martin Bromley

2. Date of Death Month Day Year: January 9, 2001

3. Time of Death: 5 09 PM

4a. Facility Name (If not institution, give street and number): 5709 47th Avenue

4b. City, Town, or Location of Death: Riverdale

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-46-1132

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 64 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 24, 1936

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Riverdale

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 5709 47th Avenue

10f. Zip Code: 20737

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: 1956-1957

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Inspector

16b. Kind of Business/Industry: Litton Industries

17. Father's Name (First, Middle, Last): William O. Bromley

18. Mother's Name (First, Middle, Maiden Surname): Mary T. Kline

19a. Informant's Name/Relationship (Type, Print): Edla C. Bromley - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5709 47th Avenue, Riverdale, MD 20737

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MD Veterans Cemetery

Date: 01/12/01

20c. Location - City or Town, State: Crownsville, MD

21. Signature of Funeral Service Licensee: Dorothy Jean Dietz

22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lung Cancer — 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Emphysema, Pneumonia

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D52298

29d. Date signed (Month, Day, Year): JAN. 11/2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DIVYA VERMA 7525 Greenway Center Dr., Suite 202, Greenbelt, MD 20770

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01906

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
JOHN W. BEANE	JANUARY 13, 2001	1:30 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MONTGOMERY GENERAL HOSPITAL	OLNEY	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-16-5746	1 [X] M 2 [ ] F	77 Yrs.			Nov 4, 1923	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Gaithersburg	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
20 East Deer Park Drive	20877	United States

11. Marital Status	12. Was Decedent Ever In U.S. Armed Forces? If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No 1/30/43 - 12/12/45	1 [ ] Yes 2 [X] No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Electrician	Federal Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Harry M. Beane	Katherine Fish

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Marion C. Beane, Wife	20 East Deer Park Drive, Gaithersburg, MD 20877

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Parklawn Memorial Park	Jan 16, 2001	Rockville, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	DeVol Funeral Home 10 East Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Angiosarcoma of Liver	months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	D35635	January 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Krum, 18111 Prince Philip Dr. Olney, MD 20832

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 16 2001	▶ Geneva B Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01907

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Caroline Edna Bieber
2. Date of Death (Month, Day, Year): January 12, 2001
3. Time of Death: 1:40 P.M.
4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 142-10-7363
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 28, 1919
9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Williamsport
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 9 Hopewell Road Apt. 9G
10f. Zip Code: 21795
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 1
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Payroll Accountant
16b. Kind of Business/Industry: Truck Manufacturer

17. Father's Name *(First, Middle, Last)*: Louis George Bieber
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Gertrude Hawks

19a. Informant's Name/Relationship *(Type, Print)*: Carol L. Hess Niece
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 938 Bard Dr. Chambersburg, Pennsylvania 17201

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Smithsburg Crematory
Date: Jan. 16, 2001
20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: David E Osborne
22. Name and Address of Facility: Osborne Funeral Home 425 South Conococheague St. Williamsport, Maryland 21795

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock or heart failure. List only one cause on aach lina.

Approximate Interval Between Onset and Death

Immediata Cause (Finat disease or condition resulting in death)
a. Respiratory Failure
Due to (or as a consequance of):
b. Probable pulmonary Embolus — 3-4hrs
Due to (or as a consequence of):
c.
Due to (or as a consequenca of):
d.

Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa rafarred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only ona)*: Hospital: 1☑ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and placa, and due to the causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, daath occurred at tha time, date and placa, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: MP
29c. License number: D30851
29d. Date signed *(Month, Day, Year)*: 1/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gary L DeLuchis 249 Mill St Hagerstown MD 21740

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Caralyn E. Bieber DOD 1-12-01 1340 PM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01908

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Addie Mae Broadus

2. Date of Death Month / Day / Year: January 14, 2001

3. Time of Death: 1549

4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown, MD

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 217 32 5633

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 1/21/1918

9. Birthplace *(State or Foreign Country)*: KY

Usual Residence of Decedent

10a. State: MD

10b. County: Washington

10c. City, Town or Location: Hagerstown, MD. 21740

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 673 Forest Drive

10f. Zip Code: 21740

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 1+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry:

17. Father's Name *(First, Middle, Last)*: Dr. Henry Cole

18. Mother's Name *(First, Middle, Meiden Surname)*: Susan Cole

19a. Informant's Name/Reletionship *(Type, Print)*: John Broadus, JR. (son)

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 462 Park Pl. Hagerstown, MD. 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Rest Haven Cemetery

Date: 1.20/01

20c. Location - City or Town, State: Hagerstown, MD.

21. Signature of Funeral Service Licensee: Mary Lee Watson

22. Name and Address of Facility: Watson Funeral Home 24 W. Bethwl St. Hagerstown, MD 21740

Physician /Medical Examiner

23a. Part1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert feilure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death)

a. Cardiac Arrest — 3 minutes

Due to (or es a consequence of):

b. Ventricular Fibrillation

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last

Due to (or es a consequence of):

c. Coronary Artery Disease

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Type II Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Menner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier:

29c. License number: D 27898

29d. Date signed *(Month, Day, Year)*: 1-16-01

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): FRANCISCO L. ANDRADE 350 MILL ST. Hagerstown, MD 21740

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Broadus, Addie Mae 304257849G

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01909

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HELEN BAUROTH
2. Date of Death (Month, Day, Year): January 15, 2001
3. Time of Death: 1:05 P.M.
4a. Facility Name *(If not institution, give street and number)*: Homewood at Williamsport
4b. City, Town, or Location of Death: Williamsport
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 207-40-7327
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 13, 1909
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Williamsport
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 16505 Virginia Avenue
10f. Zip Code: 21795
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: John T. Morgan
18. Mother's Name *(First, Middle, Maiden Surname)*: Alice Drysdale

19a. Informant's Name/Relationship *(Type, Print)*: Alan R.Bauroth Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10850 Oak Valley Drive, Hagerstown, Md. 2174

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Smithsburg Crematorium — Date: 01-16-2001
20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: R. Neal Brady
22. Name and Address of Facility: Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — 1 week
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes mellitus Type II, monoclonal gammopathy, Anemia, Demyelinating neuropathy

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D26606
29d. Date signed *(Month, Day, Year)*: Jan 15, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andrew Coffman 747 Northern Ave Hagerstown MD 21742

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001
32. Registrar's Signature: Diane B Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1-15-01 1:05 PM

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Helen Bauroth

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01910

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANN ELDRED BARRAT
2. Date of Death (Month, Day, Year): JAN. 12, 2001
3. Time of Death: 9:30 PM
4a. Facility Name (If not institution, give street and number): HOMEWOOD AT WILLIAMSPORT
4b. City, Town, or Location of Death: WILLIAMSPORT
4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 232-76-2208
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2/28/1924
9. Birthplace (State or Foreign Country): MASSACHUSETTS

Usual Residence of Decedent

10a. State: WV
10b. County: JEFFERSON
10c. City, Town or Location: SHEPHERDSTOWN
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: PO BOX 1622 (FALLING SPRINGS FARMS)
10f. Zip Code: 25443
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): JAMES RODMAN ELDRED
18. Mother's Name (First, Middle, Maiden Surname): ANNA DUFFY

19a. Informant's Name/Relationship (Type, Print): JOSEPH G. BARRAT, JR./HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): PO BOX 1622, SHEPHERDSTOWN, WV 25443

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): SMITHSBURG CREMATORY
Date: 1/13/01
20c. Location - City or Town, State: SMITHSBURG, MARYLAND

21. Signature of Funeral Service Licensee: Charles M. Brown
22. Name and Address of Facility: BROWN FUNERAL HOME, 327 W. KING ST., PO BOX 821, MARTINSBURG, WV 25402

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	VENTRICULAR TACHYCARDIA	MINUTES
Due to (or as a consequence of):	HYPOXEMIA	HOURS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.		
Due to (or as a consequence of):	PNEUMONIA	1-2 DAYS
c.		
Due to (or as a consequence of):		
d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: SEVERE DEPRESSION. CHRONIC ATRIAL FIBRILLATION. RESTRICTIVE LUNG DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MEDICAL DIRECTOR
29c. License number: D7067
29d. Date signed (Month, Day, Year): 1/13/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STEPHEN E. THETFORD, MD 747 DONAGHOE AVE. HAGERSTOWN, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: [signature] D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01911

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Anderson Henson L. Butler Jr.

2. Date of Death (Month, Day, Year): January 14, 2001

3. Time of Death: 12:50AM

4a. Facility Name *(If not institution, give street and number)*: 3998 Turner Road

4b. City, Town, or Location of Death: Brandywine

4c. County of Death: Charles

Funeral Director

5. Social Security Number: 213-46-9022

6. Sex: X M 2 F

7. Age *(In yrs. last birthday)*: 56 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: October 30,44

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Charles

10c. City, Town or Location: Brandywine

10d. Inside City Limits: 1 X Yes 2 No

10e. Street and Number: 3998 Turner Road

10f. Zip Code: 20613

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 Never Married 2 X Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: State Government

16b. Kind of Business/Industry: Grounds Keeper

17. Father's Name *(First, Middle, Last)*: Henson L. Butler Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Johnson

19a. Informant's Name/Relationship *(Type, Print)*: Viola Butler/ Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3998 Turner Rd, Brandywine Maryland 20613

20a. Method of Disposition: X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Philips Ch.Cem.

Date: 1/22/01

20c. Location - City or Town, State: Aquasco Maryland

21. Signature of Funeral Service Licensee: Lloyd Estep

22. Name and Address of Facility: M191 Adams Funeral Home P.A. Aquasco MD 20608

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Esophageal Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No

25. Was case referred to medical examiner? 1 Yes 2 XXX No

26. Place of Death *(Check only one)*: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 X Residence 6 Other *(Specify)*

27. Manner of Death: XXX 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: XXX 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Krishan M. Mathur

29c. License number: D28352

29d. Date signed *(Month, Day, Year)*: January 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Krishan Mathur, MD., P.O. Box 1703, La Plata, MD 20646

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RKD

01-0103-031
01-006

FRANK CARMONA amend item 23a,27,28a-f per me G792 2/5/01 yf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01912

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Franciso	Raymond	Carmona	JANUARY	6,	2001	8:48A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
OAKVIEW DRIVE IN WOODS	SILVER SPRINGS	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-88-8077	1☒M 2☐F	37 Yrs.					Aug 29 1963	Hawaii

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Silver Spring	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8432 12th Ave.	20903	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 1982-86	1☒Yes 2☐No Specify: Puerto Rican	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Military Police	U.S. Army

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Carlos M. Carmona-Quinones	Nicole J. Jean

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Carlos Carmona-Quinones/Father	8432 12th Ave., Silver Spring, MD 20903

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, cramatory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cramation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Chesapeake Crematory Inc	Jan 15 2001	Beltsville, MD

21. Signature of Funeral Service Licensee: ▶ Beverly L Heath

22. Name and Address of Facility: Rapp Funeral & Cremation Services, Stephen D. Lohrmann, 933 Gist Ave. Silver Spring, MD 20910

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MIXED DRUG INTOXICATION AND HYPOTHERMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) SCENE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☒Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	found 1/6/01	unknown M	1☐Yes 2☒No	subject ingested drugs/prolonged cold exposure

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): wooded area

28f. Location (Street and Number or Rural Route Number, City or Town, State): Oakview Dr., Silver Spring, Md

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Stephen S. Radentz, MD	O.C.M.E.	JANUARY 7, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 17 2001	pending ▶ P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01913

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Anne Collins
2. Date of Death (Month, Day, Year): January 4, 2001
3. Time of Death: 2:51PM
4a. Facility Name *(If not institution, give street and number)*: 16010 Excalibur Rd. D119
4b. City, Town, or Location of Death: Bowie
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-16-2841
6. Sex: 1☐ M 2☒ F XX
7. Age *(In yrs. last birthday)*: 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 25, 1920
9. Birthplace *(State or Foreign Country)*: Norfolk, VA.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1☐ Yes 2☒ No X
10e. Street and Number: 16010 Excalibur Rd. D119
10f. Zip Code: 20716
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No XX If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No XX *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: At Home

17. Father's Name *(First, Middle, Last)*: Algernon Vernon Gibbs
18. Mother's Name *(First, Middle, Maiden Surname)*: Ruby Lee James

19a. Informant's Name/Relationship *(Type, Print)*: Robert S. Collins/Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: Same as item 10

20a. Method of Disposition: 1☒ Burial X 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Resurrection Cemetery
Date: 1/8/01
20c. Location - City or Town, State: Clinton, Md.

21. Signature of Funeral Service Licensee: ▶ George P. Kalas
22. Name and Address of Facility: George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Chronic Obstructive Pulmonary Disease — 8 Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown X

24a. Was an autopsy performed? 1☐ Yes 2☒ No X
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No XX
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence X 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural XX 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. XX
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Mark Parkhurst MD
29c. License number: D24093
29d. Date signed *(Month, Day, Year)*: JANUAY 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mark Parkhurst, M.D. 7305 Balt. Ave. College Park, Md. 20740

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 8 2001
32. Registrar's Signature: ▶ Georgia B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-0010-033
B.K.S

ANTONIO B. COLLIER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01914

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Antonio B. Collier
2. Date of Death (Month, Day, Year): JAN. 1, 2001
3. Time of Death: 0450 AM
4a. Facility Name (If not institution, give street and number): FORT WASHINGTON HOSPITAL
4b. City, Town, or Location of Death: FORT WASHINGTON
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 577-11-0998
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 17 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 19, 1983
9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Suitland
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4119 Crab Apple Ct.
10f. Zip Code: 20746
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): Walter Collier
18. Mother's Name (First, Middle, Maiden Surname): Rosa McNeil

19a. Informant's Name/Relationship (Type, Print): Rosa Collier/ Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4119 Crab Apple Ct. Suitland, Md. 20746

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glenwood Cemetery
Date: 1/6/01
20c. Location - City or Town, State: Washington, D.C.

21. Signature of Funeral Service Licensee: Keith A. Sparks 1001885
22. Name and Address of Facility: Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Head Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): 1-1-2001
28b. Time of Injury: 413 A M
28c. Injury at Work? 1☐ Yes 2☑ No
28d. Describe how injury occurred: motor vehicle collision
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): street
28f. Location (Street and Number or Rural Route Number, City or Town, State): Md Rt 210 Accokeek Md

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis Chutkow
29c. License number: O.C.M .E
29d. Date signed (Month, Day, Year): JAN. 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chutkow 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001
32. Registrar's Signature: [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(6)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01915

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Colight Carmichael	January	4	2001	7:23 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Southern Maryland Hospital	Clinton	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
250-40-9370	1☒M 2☐F	72 Yrs.					June 19, 1928	South Carolina

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Capitol Heights	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1114 Drum Ave.	20743	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10th		Clerk - Super Fresh	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James Carmichael	Ruth Hayes

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Janie Carmichael - Wife	1114 Drum Ave., Capitol Heights, MD 20743

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Glenwood Cemetery	1/10/2001	Washington, D.C.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
John T. Stewart III	Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Severe atherosclerotic coronary heart disease	years
Due to (or as a consequence of):	b. Chronic obstructive pulmonary disease	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Bronchopneumonia	days
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Bilateral carotid occlusive disease

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☒Yes 2☐No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)

1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Peter W. Tim MD	D00 12884	JAN. 8 '01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PETER W. TIM M.D. 7900 old Branch ave. suite 101 clinton, Maryland 20735

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 09 2001	Brenda B. Sparks

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Carmichael, Colight

SR 1-4701 @ 7:23 Dr. Yim

(5)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01916

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BERNICE CARROLL
2. Data of Death — Month: Jan Day: 5 Year: 2001
3. Time of Death: 1250
4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-50-5629
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 63 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb 20, 1937
9. Birthplace (State or Foreign Country): Washington DC

16 2 1

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 8106 Chapel Cove DR
10f. Zip Code: 20707
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 2
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Contact Representative
16b. Kind of Business/Industry: Fed Govt

17. Father's Name (First, Middle, Last): Andrew Williams
18. Mother's Name (First, Middle, Maiden Surname): Bernice Brown

19a. Informant's Name/Relationship (Type, Print): Stanton F. Blyther / Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8106 Chapel Cove Drive, Laurel, MD 20707

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Memorial Park
Date: 1-13-01
20c. Location - City or Town, State: Landover, md

21. Signature of Funeral Service Licensee: Larry L. Simmons
22. Name and Address of Facility: Alexander s. Pope Funeral HOme
2617 Penn.Ave S.E. Washington DC 20020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sarcoidosis — Years

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Pritam Sd
29c. License number: D 28998
29d. Date signed (Month, Day, Year): Jan 6, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PRITAM T SAINI MD
9101 Cherry Ln Suite 211, Laurel MD 20708

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001
32. Registrar's Signature: Geraldine D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

16

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01917

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Clifton Lowell Collins
2. Date of Death Month: January Day: 7, Year: 2001
3. Time of Death: 2241
4a. Facility Name *(If not institution, give street and number)*: Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-52-8337
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 62 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 11/18/38
9. Birthplace *(State or Foreign Country)*: Arlington, Va.

Usual Residence of Decedent

10a. State: D.C.
10b. County: N/A
10c. City, Town or Location: Washington
10d. Inside City Limits: ☒ Yes 2 ☐ No
10e. Street and Number: 121 Walnut Street, N.W.
10f. Zip Code: 20012
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4 or 5+): 4 Yrs.
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Civil Engineer
16b. Kind of Business/Industry: D.C. Government

17. Father's Name *(First, Middle, Last)*: William Theodore Collins
18. Mother's Name *(First, Middle, Maiden Surname)*: Jieudetta Jones

19a. Informant's Name/Relationship *(Type, Print)*: Jacqueline D. Collins/Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 121 Walnut St., N.W., Washington, D.C. 20012

20a. Method of Disposition: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lincoln Mem. Cem. — Date: 1/16/01
20c. Location - City or Town, State: Suitland, Md.

21. Signature of Funeral Service Licensee: Gary W. Pratt
22. Name and Address of Facility: H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Wash., D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction
Due to (or as a consequence of):
b. Atherosclerotic Coronary Artery disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28b. Time of Injury: M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Date of Injury *(Month, Day, Year)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: James K. Lightfoot, M.D.
29c. License number: 52326
29d. Date signed *(Month, Day, Year)*: 1/8/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James K. Lightfoot M.D. Washington Adventist Hospital

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001
32. Registrar's Signature: George B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

RJD
01-92-033
WALTER COTTER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01918

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Walter Owen Cotter
2. Date of Death: Month JANUARY Day 05 Year 2001
3. Time of Death: 19:51
4a. Facility Name (If not institution, give street and number): 5532 KAREN ELAINE DR. #1731
4b. City, Town, or Location of Death: NEW CARROLLTON
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 577-44-0215
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 66 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 4, 1934
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: New Carrollton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5532 Karen Elaine Drive #1731
10f. Zip Code: 20784
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Glazer
16b. Kind of Business/Industry: Private
17. Father's Name (First, Middle, Last): John Milton Cotter
18. Mother's Name (First, Middle, Maiden Surname): Tennie Mae Smith
19a. Informant's Name/Relationship (Type, Print): Judy Cotter - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Box 11, Charlotte Hall, Maryland 20622
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 01/11/01
20c. Location - City or Town, State: Alexandria, Virginia
21. Signature of Funeral Service Licensee: Claudette Gasch Jamin
22. Name and Address of Facility: Gasch's Funeral Home, P. A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hypertensive atherosclerotic Cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Alcoholism

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? Limited 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) SCENE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stephen L. Radentz, M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): JANUARY 06, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 01919

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Mildred Alma Chaney

2. Date of Death Month Day Year: January 10, 2001

3. Time of Death: 3:07 am

4a Facility Neme *(If not Institution, give street and number)*: Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-18-8973

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: Apr. 25, 1920

9. Birthplace *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Prince George's

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3940 Madison Street

10f. Zip Coda: 20781

10g. Citizen of What Country?: U.S.A.

11. Merital Stetus: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Blеck, Whita, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementery/Secondery (0-12): Collage (1-4or 5+): 3

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Fathar's Nema *(First, Middla, Last)*: Claude William Gardner

18. Mother's Neme *(First, Middle, Meiden Sumame)*: Irene Beall

19a. Informent's Neme/Reletionship *(Type, Print)*: Janice C. Robbins - Daughter

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 8012 Cattail Court, Frederick, MD 21701

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: St. John's Cemetery

Date: 01/13/01

20c. Location - City or Town, Stete: Beltsville, MD

21. Signeture of Funerel Service Licensee: Alex Jones

22. Neme end Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that caused tha death. Do not enter the mode of dying, such es cardiec or raspiretory errest, shock, or heert faiture. List only one ceuse on eech line.

Approximete Interval Between Onset and Deeth

Immediete Cause (Finet diseese or condition resulting in deeth):

a. RESPIRATORY FAILURE — 11 hrs.

Dua to (or as a consequence of):

b. ACUTE PULMONARY EDEMA — 24 hrs.

Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Last

Due to (or es e consequence of):

c. CORRONARY ARTRY DISEASE — Severd yrs.

Dua to (or as a consequenca of):

d. ATHEROSCLEROTIC HEART DISEASE — Several yrs.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

Adenocarcinoma Lung (Right)

Chronic obstructive Pulmonary Disease

Hypertension ; Renal Failure ; Anemia

23b. Did tobecco use contribute to the causa of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was case referred to medicet examiner? 1☐ Yes 2☑ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☑ Neturat 2☐ Accident 3☐ Sulcida 4☐ Homicide 5☐ Pending invastigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use as the burial-transit

29e. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, deta and place, and due to tha cause(s) end menner steted.

29b. Signatura and titla of certifier: T. M. Din M.D.

29c. License number: D 22549

29d. Dete signed *(Month, Day, Year)*: JANUARY 10, 2001

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print): G.M. DIN, M.D. 6510 Kenilworth Ave Riverdale M.D. 20737

(15)

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01920

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Grayson Bernard Castle

2. Date of Death Month Day Year: January 9, 2001

3. Time of Death: 4:45 PM

4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 214-10-3059

8. Sex: 1 ☐ M 2 ☒ F

7. Age *(In yrs. last birthday)*: 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 29, 1909

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Adamstown

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 5614 Adamstown Road

10f. Zip Code: 21710

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Carpenter

16b. Kind of Business/Industry: General Contracting

17. Father's Name *(First, Middle, Last)*: Harry Martin Castle

18. Mother's Name *(First, Middle, Maiden Surname)*: Lillie Rebecca Lambert

19a. Informant's Name/Relationship *(Type, Print)*: Brenda R. Keagan/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 220 Carroll Parkway, Frederick, Maryland 21701

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mount Olivet Cemetery

Date: Jan. 13, 2001

20c. Location - City or Town, State: Frederick, Md.

21. Signature of Funeral Service Licensee: Richard C. C-Basford M00021

22. Name and Address of Facility: Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cerebravascular stroke — 1 Day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Dementia (Alzheimer's type)

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D51643

29d. Date signed *(Month, Day, Year)*: 1/10/01

30. Name and address of person who completed cause of death (item 23a) (Type, Print): Hiren N Shah, MD #100 1711 Thomas Johnson Dr, Frederick MD 21702

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001

32. Registrar's Signature: Geneva B Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 01921

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: George Allen Crummitt Sr
2. Date of Death Month Day Year: January 10, 2001
3. Time of Death: 10:10 AM
4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 212-24-5295
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 72 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 7, 1928
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 28 East South Street
10f. Zip Code: 21701
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mason
16b. Kind of Business/Industry: Mason Contracting

17. Father's Name *(First, Middle, Last)*: William Crummitt, Sr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Edna Keith

19a. Informant's Name/Relationship *(Type, Print)*: Veronica B. Crummitt/Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 28 East South Street, Frederick, Maryland 21701

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Olivet Cemetery
Date: Jan. 13, 2001
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Richard C. Basford M00021
22. Name and Address of Facility: Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Chronic Obstructive Pulmonary Disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure Ischemic Cardiomyopathy

23b. **Did tobacco use contribute to the cause of death?** 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D26576
29d. Date signed *(Month, Day, Year)*: JAN 10 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALLEN J. GILSON 1475 TANEY AVE FRED MD 21702

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001
32. Registrar's Signature: Donna D Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01922

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MICHAEL MORSE COONEY
2. Date of Death (Month, Day, Year): January 11, 2001
3. Time of Death: 8:45 AM

4a. Facility Name (If not institution, give street and number): 104 Lombardy Drive
4b. City, Town, or Location of Death: Middletown
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 220-28-3676
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 4, 1935
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Middletown
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 104 Lombardy Drive
10f. Zip Code: 21769
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: Korean
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sr. Executive Vice President
16b. Kind of Business/Industry: F&M Bank

17. Father's Name (First, Middle, Last): William Smythe Cooney
18. Mother's Name (First, Middle, Maiden Surname): Ruth Price Herbert

19a. Informant's Name/Relationship (Type, Print): Patrick Cooney (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 29 Boileau Court, Middletown, Maryland 21769

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory
Date: 1/12/01
20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: Robert E. Dailey Jr.
22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.? 1201 NORTH MARKET STREET, FREDERICK, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Prosate Cancer — 3 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D43091
29d. Date signed (Month, Day, Year): 1/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Saeed A. Zaidi, MD 801 Toll House Avenue, Frederick, MD 21701

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01923

EUGENE CORDES

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eugene Nicholas CORDES
2. Date of Death: Month January, Day 11, Year 2001
3. Time of Death: 3:00 a.m.
4a. Facility Name (If not institution, give street and number): 82 Manor Drive , Apt. 101
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 577-58-5123
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 57 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): May 29,1943
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 82 Manor Drive, Apt. 101
10f. Zip Code: 21740
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No. If Yes, Give Year or Dates: 1962-1969
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): communications worker
16b. Kind of Business/Industry: government

17. Father's Name (First, Middle, Last): Eldin Lee Green
18. Mother's Name (First, Middle, Maiden Surname): Rose Theresa Breheny

19a. Informant's Name/Relationship (Type, Print): Tina Cordes - wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 82 Manor Dr. #101, Hagerstown, Md. 21740

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hagerstown Crematory
Date: 1-12-01
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott Minnich
22. Name and Address of Facility: MINNICH FUNERAL HOME, 415 E. Wilson Blvd., Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Coronary Artery Disease — years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease; Obstructive Sleep apnea.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA. Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D41786
29d. Date signed (Month, Day, Year): 1/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Alencherry MD, 12821 Oak hill ave, Hagerstown, MD 21742

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001
32. Registrar's Signature

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01924

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jane Omega Gordon CAUDELL
2. Date of Death Month: Jan Day: 11 Year: 01
3. Time of Death: 1830
4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214-09-7093
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct.18,1918
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 300 W. Northern Avenue
10f. Zip Code: 21742
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: homemaker
16b. Kind of Business/Industry: her own home

17. Father's Name *(First, Middle, Last)*: Clinton Eavey
18. Mother's Name *(First, Middle, Maiden Surname)*: Eliza B. Shafer

19a. Informant's Name/Relationship *(Type, Print)*: James K. Caudell - son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 223 Douty Dr., Hedgesville, W.Va. 25427

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rest Haven Cemetery — Date: 1-15-01
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signeture of Funeral Service Licensee: Scott M Minnich
22. Name and Address of Facility: MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Chronic Infilltrative Lung Disease — years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D41786
29d. Date signed *(Month, Day, Year)*: 1/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Hencherry MD, 12821 Oak Hill ave, Hagerstown, MD 21742

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Caudell, Jane Omega

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01925

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gladys V. Duckett

2. Data of Death — Month: January Day: 6 Year: 2001

3. Time of Death: 10:10am

4a. Facility Name *(If not institution, give street and number)*: Doctors Community Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 218-34-7324

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 93 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Data of Birth *(Month, Day, Year)*: December 23, 1907

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Capital Heights

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 7357 Shady Glen Terrace

10f. Zip Code: 20743

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 10th

College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: House Keeping

16b. Kind of Business/Industry: Government

17. Father's Name *(First, Middle, Last)*: Walter Snowden

18. Mother's Name *(First, Middle, Maiden Surname)*: Janie Williams

19a. Informant's Name/Relationship *(Type, Print)*: Ann Rollins/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1871 Quebec St. Seven, MD 21144

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Resurrection Cemetery

Date: 01/11/01

20c. Location - City or Town, State: Clinton, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: J.B. Jenkins Funeral Home, 7474 Landover Rd. Landover, MD 20785

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):

a. Pneumonia — 6 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D35820

29d. Date signed *(Month, Day, Year)*: 1/06/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter Eckberg M.D. 14300 Gallant Fox Lane #110 BOWIE, MD 20715

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 09 2001

32. Registrar's Signature: [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Duckett, Gladys

SR

(5)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01926

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JACK DICKENS SR.

2. Date of Death: Month JANUARY Day 4 Year 2001

3. Time of Death: 11:00 am

4a. Facility Name *(If not institution, give street and number)*: 111 AMBER LANE

4b. City, Town, or Location of Death: HUNTINGTOWN

4c. County of Death: CALVERT

Funeral Director

5. Social Security Number: 215-20-3365

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 72 Yrs.

If Under 1 Yeer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: APRIL 28 1928

9. Birthplece *(Stete or Foreign Country)*: NORTH CAROLINA

Usuel Residence of Decedent

10a. Stete: MARYLAND

10b. County: CALVERT

10c. City, Town or Location: HUNTINGTOWN

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 111 AMBER LANE

10f. Zip Code: 20639

10g. Citizen of What Country?: U.S.A.

11. Marital Stetus: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1944

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Rece - Americen Indien, Bleck, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: MECHANIC

16b. Kind of Business/Industry: AUTO

17. Father's Neme *(First, Middle, Last)*: RICHARD DICKENS

18. Mother's Neme *(First, Middle, Meiden Surneme)*: DORIS SMITH

19a. Informent's Neme/Reletionship *(Type, Print)*: JACK DICKENS JR / SON

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 111 AMBER LANE HUNTINGTOWN, MD 20639

20a. Method of Disposition: 1 ☒ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, crematory or other piece)*: FORT LINCOLN CEMETERY

Dete: 1-8-01

20c. Locetion - City or Town, Stete: BRENTWOOD, MARYLAND

21. Signeture of Funerel Service Licensee: Shawn E Williams

22. Neme end Address of Feciility: FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG ROAD BRENTWOOD, MARYLAND 20722

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heert feilure. List *only one* cause on each line.

Approximete Intervel Between Onset and Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth)

a. CARDIO RESPIRATORY FAILURE

Due to (or es e consequence of):

OROPHARYNGEAL CANCER

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Last

b.

Due to (or es e consequence of):

c. LYMPHOMA

Due to (or es e consequence of):

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

d.

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

KYPHOSIS

23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probebly 4 ☒ Unknown

24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospitel: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other *(Specify)*

27. Menner of Death: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Locetion *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of *my* knowledge, death occurred et the time, dete end piece, and due to the cause(s) and manner es stated. 2 ☐ **Medicel Exeminer:** On the basis of exeminetion end/or investigetion, in *my* opinion, death occurred at the time, dete end piece, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: D. Shah 1/8/01

29c. License number: D50290

29d. Dete signed *(Month, Dey, Yeer)*: JANUARY 8, 2001

30. Neme and edress of person who completed cause of death (Item 23a) (Type, Print): DHIREN SHAH, M.D. 110 HOSPITAL ROAD SUITE 303 PRINCE FREDRICK, MD 20678

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 09 2001

32. Registrer's Signeture: Geraldine D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01927

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EMMA DAVIS
2. Date of Death Month Day Year: January 6, 2001
3. Time of Death: 4:02 AM
4e. Facility Name *(If not institution, give street and number)*: Fort Washington Hospital
4b. City, Town, or Location of Death: Fort Washington
4c. County of Death: Prince Georges'

Funeral Director

5. Social Security Number: 105-22-3491
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 86 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 01-21-14
9. Birthplace *(State or Foreign Country)*: NottawayCo.,VA

Usual Residence of Decedent

10e. State: Maryland
10b. County: Prince Georges'
10c. City, Town or Location: Suitland
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3940 Bexley Place, Apt. # 519
10f. Zip Code: 20746
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorcad
12. Wes Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Raca - American Indien, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12); College (1-4or 5+): 2
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife
16b. Kind of Business/Industry:

17. Fether's Name *(First, Middle, Last)*: James Peterson
18. Mother's Name *(First, Middle, Meiden Surname)*: Lelia Jones

19e. Informant's Name/Relationship *(Type, Print)*: Russell L. Davis / SON
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9002 Rollingwood Drive, Ft. Wash., MD 20744

20a. Method of Disposition: 1☐ Buriel 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory
Date: 01-10-01
20c. Location - City or Town, Stete: Beltsville, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Feciility: Strickland Funeral Services, P.A. 6500 Allentown Rd, Camp Springs, MD 20748

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in death)
e. Cardiovascular Arrest

Due to (or es e consequence of):
b. SHOCK

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

Due to (or as e consequence of):
c. Upper Gastro Intestinal Bleeding

Due to (or es a consequence of):
d. Probable Peptic Ulcer and Gastritis

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
RENAL INSUFFICIENCY
PROBABLE SEPSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings availeble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and plece, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and placa, end due to the ceuse(s) and manner stated.

29b. Signeture and title of certifier: [signature]
29c. License number: D0024523
29d. Date signed *(Month, Day, Year)*: January 9, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Obiora Ogbuawa, MD, 11701 Livingston Rd., Ft. Washington, MD 20744

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 10 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: Tha law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by tha attending physician and completely filled in by tha funeral director, page 2 should be detached for use as tha burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01928

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SISTER MONICA V. DAVIS
2. Date of Death (Month, Day, Year): JANUARY 10, 2001
3. Time of Death: 10:35 AM
4a. Facility Name (If not institution, give street and number): ST. VINCENT CARE CENTER
4b. City, Town, or Location of Death: EMMITSBURG
4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 159-05-5903
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT. 31, 1912
9. Birthplace (State or Foreign Country): PA.

Usual Residence of Decedent

10a. State: MD
10b. County: FREDERICK
10c. City, Town or Location: EMMITSBURG
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 135 S. SETON AVE.
10f. Zip Code: 21727
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHER
16b. Kind of Business/Industry: SISTER OF NOTRE DAME

17. Father's Name (First, Middle, Last): AMASA CLEMENT DAVIS
18. Mother's Name (First, Middle, Maiden Surname): ALICE CROWTHER

19a. Informant's Name/Relationship (Type, Print): SR. MARY ADELE WHITE/SUPERIOR
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19 WINWARD CT., THURMONT, MD. 21788

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): SISTERS OF NOTRE DAME | Date: 1/13/2001
20c. Location - City or Town, State: ELLICOTT CITY, MD.

21. Signature of Funeral Service Licensee: John M. Skiles
22. Name and Address of Facility: SKILES FUNERAL HOME, 210 W. MAIN ST., EMMITSBURG, MD. 21727-0427

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Congestive Heart Failure	2 mos
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Valvular Heart Disease	6 yrs.
	Due to (or as a consequence of):	
	c. Ischemic Cardiomyopathy	8 yrs
	Due to (or as a consequence of):	
	d. Atherosclerosis	20 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Parkinsons Disease - Advanced

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Donita J. Krempel-Portier
29c. License number: H44987
29d. Date signed (Month, Day, Year): 01/10/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DONITA J. KREMPEL-PORTIER, 52 WATER ST THURMONT, MD 21788

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001
32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0246-021
jhm
JAMES COLBURN
DRAKE

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01929

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: JAMES COLBURN DRAKE
2. Date of Death Month / Day / Year: JANUARY 14, 2001
3. Time of Death: 22:48 PM
4a. Facility Neme *(If not institution, give street and number)*: 2919 GREEN HILL COURT
4b. City, Town, or Location of Death: IJAMSVILLE
4c. County of Deeth: FREDERICK

Funeral Director

5. Social Security Number: 213-44-5501
6. Sex: 1☐ M 2☐ F — X
7. Age *(In yrs. lest birthday)*: 55 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Yeer)*: 07-16-1945
9. Birthplace *(Stete or Foreign Country)*: Washington, D.C.

Usuel Residence of Decedent

10a. State: MD
10b. County: Frederick
10c. City, Town or Location: Ijamsville
10d. Inside City Limits: 1☐ Yes 2☐ No — X
10e. Street and Number: 2919 Green Hill Court
10f. Zip Code: 21754
10g. Citizen of Whet Country?: United States

11. Merital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 12 — College (1-4or 5+): 4
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Administrator
16b. Kind of Businass/Industry: Federal Government

17. Father's Neme *(First, Middle, Last)*: Norman C. Drake
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Eva Kline

19a. Informant's Neme/Relationship *(Type, Print)*: Dorothy Drake/ Wife
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 2919 Green Hill Court, Ijamsville, MD 21754

20a. Method of Disposition: 1☐ Buriel 2☒ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Hagerstown Crematory
Dete: 01-16-01
20c. Location - City or Town, State: Hagerstown, MD

21. Signature of Funerel Service Licensee: ▶ [signature]
22. Neme end Address of Feciliity: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death)
a. Contact gunshot Wound of Head
Due to (or es a consequence of):
b.
Due to (or as e consequence of):
c.
Due to (or as e consequence of):
d.

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown — X

24a. Wes an autopsy performed? 1☒ Yes 2☐ No — X
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No — X

25. Was case referred to medical examiner? 1☒ Yes 2☐ No — X
26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* SCENE — X

27. Manner of Death: 1☐ Netural 2☐ Accident 3☒ Suicide — X 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Day Yeer)*: Found 1/14/01
28b. Time of Injury: 2230HRS
28c. Injury et Work? 1☐ Yes 2☒ No — X
28d. Describe how injury occurred: Subject shot self
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*: Yard of residence
28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*: 2919 Green Hill Court Ijamsville Maryland

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and menner as stated. 2☒ **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, dete and plece, and due to the cause(s) end manner steted. — X
29b. Signature and title of certifier: ▶ Theodore M. King MD
29c. License number: OCME
29d. Dete signed *(Month, Day, Yeer)*: JANUARY 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Dey, Yeer)*: JAN 16 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01930

James Leon DISHMAN

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

8

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Leon Dishman
2. Date of Death: Month January Day 3, Year 2001
3. Time of Death: 9:10 PM
4a. Facility Name (If not institution, give street and number): Doctors Community Hospital
4b. City, Town, or Location of Death: Lanham
4c. County of Death: Pr. Georges

Funeral Director

5. Social Security Number: 579-24-0546
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): February 28, 1926
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Hollywood
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 24494 Placid Harbor Way
10f. Zip Code: 20636
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [XX] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942-1972
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seaman-Mariner
16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): James Lorenzo Dishman
18. Mother's Name (First, Middle, Maiden Surname): Katherine A. Johnson

19a. Informant's Name/Relationship (Type, Print): Denise D. Dishman, Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1935 Dunwoodie Street, Orlando, Fl. 32839

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ~~Arlington National Cemetery~~
Date: 1/12/01
20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: Roger Mayer
22. Name and Address of Facility: Sterling Funeral Service 1601 Kenilworth Avenue, Washington, DC 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death):
a. Respiratory failure — Approximate Interval Between Onset and Death: days
Due to (or as a consequence of):
b. tumor of lung / pneumothorax — months
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. acute myocardial infarction — days
Due to (or as a consequence of):
d. coronary artery disease — years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
chronic obstructive lung disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Thy Ko
29c. License number: D 22111
29d. Date signed (Month, Day, Year): Jan 4, 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THOMAS KO 4100 Gondelock Rd # 302 Lanham MD 20706

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001
32. Registrar's Signature: Brenda G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01931

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Doris Verbell DeLauney

2. Date of Death (Month, Day, Year): January 11, 2001

3. Time of Death: 7:30 PM

4a. Facility Name *(If not institution, give street and number)*: Beverly Healthcare

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 217-10-3177

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 29, 1916

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Washington

10c. City, Town or Location: Sharpsburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 110 S. Mechanic St.

10f. Zip Code: 21782

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Inspector

16b. Kind of Business/Industry: Shoe Manufacture

17. Father's Name *(First, Middle, Last)*: Allen Grafton McGraw

18. Mother's Name *(First, Middle, Maiden Surname)*: Edith Verbell Bender

19a. Informant's Name/Relationship *(Type, Print)*: Patsy S. DeLauney (daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O.Box # 526 Sharpsburg, MD 21782

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Smithsburg Crematory

Date: Jan. 12, 2001

20c. Location - City or Town, State: Smithsburg, MD 21783

21. Signature of Funeral Service Licensee: Marjorie M Shaw

22. Name and Address of Facility: OSBORNE FUNERAL HOME P.O.Box # 348 Williamsport, MD 21795

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	RENAL FAILURE	3 yrs.
Due to (or as a consequence of): b.	HYPERTENTION	10 yrs.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	PAGET'S DISEASE OF VULVA	5 yrs.
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: none

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marjorie g may

29c. License number: D28365

29d. Date signed *(Month, Day, Year)*: 1-12-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARJORIE J SHAW 368 Mill Street - Hagerstown MD 21740

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: Donna D Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01932

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Howard Dunn

2. Date of Death (Month, Day, Year): Jan. 21, 2001

3. Time of Death: 5:40A.

4a. Facility Name (If not institution, give street and number): 3701 Marble Arch Way

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 062-03-2524

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov.17,1917

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 3701 Marble Arch Way

10f. Zip Code: 20906

10g. Citizen of What Country? United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Statistician

16b. Kind of Business/Industry: International Business I.B.M. Machines

17. Father's Name (First, Middle, Last): Abraham Dunn

18. Mother's Name (First, Middle, Maiden Surname): Edna Falkenstein

19a. Informant's Name/Reletionship (Type, Print): Barbara Dunn - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1914 Park Rd., N.W. Washington, D.C. 20010

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Judean Memorial Gardens

Date: 1/23/2001

20c. Location - City or Town, State: Olney, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cerebrovascular Disease — 5 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Severe Multiinfarct Dementia

Chronic Renal Failure

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] James A Rossi MD

29c. License number: D24543

29d. Date signed (Month, Day, Year): January 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James A. Rossi, M.D. 3325 N. Leisure World Blvd. Silver Spring, Maryland 20906

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001

32. Registrar's Signature: [signature]

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended item#8 FCHD,KS 1/18/2001 — *Certificate of Death* — Also item#28 — Reg. No. per MD **2001 01933**

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOHN EDWARD EFFLAND JR.

2. Date of Death (Month, Day, Year): JANUARY 13 2001

3. Time of Death: 1:03PM

4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 219-03-9058

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: ~~June 20,1920~~ June 25,1920

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 1001 Carroll Parkway/ Apt. # 207

10f. Zip Code: 21701

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Plant Manager

16b. Kind of Business/Industry: Phone Company

17. Father's Name *(First, Middle, Last)*: John E. Effland, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Lula Kinser

19a. Informant's Name/Relationship *(Type, Print)*: JoAnn Smith Effland / Spouse

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1001 Carroll Parkway,Apt.207 / Frederick,MD 21701

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hagerstown Crematory

Date: 01-15-01

20c. Location - City or Town, State: Hagerstown,Maryland

21. Signature of Funeral Service Licensee: Raymond Peterson

22. Name and Address of Facility: Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick,MD 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. ~~Pneumonia~~ Aspiration Pneumonia

Due to (or as a consequence of):
b. Hypoxia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Myocardial Ischemia
Cerebrovascular Disease
~~Aspiration~~

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Eugene B. Casagrande

29c. License number: D40307 MARYLAND

29d. Date signed *(Month, Day, Year)*: 01-13-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Eugene B. Casagrande , 1564 Opossumtown Pike/ Frederick, MD 21702

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01934

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LEON GARRET ECTON

2. Date of Death Month Day Year: January 10 2001

3. Time of Death: 0736

4a Facility Name *(If not institution, give street and number)*: WASHINGTON COUNTY HOSPITAL

4b. City, Town, or Location of Death: HAGERSTOWN

4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 215-18-2042

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MARCH 3, 1921

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WASHINGTON

10c. City, Town or Location: BOONSBORO

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 203 POTOMAC STREET

10f. Zip Code: 21713

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☒ Yes 2☐ No If Yes, Give Yaar or Datas: 1942-1963

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SOLDIER

16b. Kind of Business/Industry: U.S. ARMY

17. Father's Name *(First, Middle, Last)*: NORMAN LESTER ECTON

18. Mother's Name *(First, Middle, Maiden Surname)*: NINA MAE EBERSOLE

19a. Informant's Name/Relationship *(Type, Print)*: BRIGITTA A. ECTON/SPOUSE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 203 POTOMAC STREET, BOONSBORO, MARYLAND 21713

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: BOONSBORO CEMETERY

Date: 1/13/01

20c. Location - City or Town, State: BOONSBORO, MARYLAND

21. Signature of Funeral Service Licensee: Paul M. Dean

22. Name and Address of Facility: BAST FUNERAL HOME 7606 Old National Pike Boonsboro, Maryland 21713

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Gastro-intestinal hemorrhage — 2 days

Due to (or as a consequence of):

b. Peptic ulcer — Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Parkinson's Disease — Years

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: 044996

29d. Date signed *(Month, Day, Year)*: January 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Zafar Malik MD 20311 Lappans Rd Boonsboro, MD 21713

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001

32. Registrar's Signature: B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

keon Garrett Ecton

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01935

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): Yvette G. Flubacher		2. Date of Death (Month, Day, Year): January 8, 2001	3. Time of Death: 11:50AM
4a. Facility Name (If not institution, give street and number): Villa Rosa Nursing Home	4b. City, Town, or Location of Death: Mitchellville	4c. County of Death: Prince George's	
5. Social Security Number: 578-54-4800	6. Sex: 1☐ M 2☒ F	7. Age (In yrs. last birthday): 71 Yrs.	If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 10, 1929	9. Birthplace (State or Foreign Country): France		

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Ft. Washington	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11810 Hickory Drive	20744	France

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Secretary	Metropolitan Club

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Albert Victorin Elie Guille	Marie Emma Pastore

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Henry M. Misiur- Friend	Same as #10

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Cedar Hill Cemetery	Jan. 12, 01	Suitland, Maryland

21. Signature of Funeral Service Licensee: Joyce P. Kalas

22. Name and Address of Facility: George P. Kalas Funeral Home, 6160 Oxon Hill Road, Oxon Hill, Maryland 20745

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Failure to thrive	weeks
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Dementia	years
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D32261	1-8-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard J. Fiddler MD 9310 Annapolis Rd, Lanham MD 20706

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 09 2001	Bernice D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01936

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Angelo Fresco
2. Data of Death: Month January Day 7, Year 2001
3. Time of Death: 1630
4a. Facility Name (If not institution, give street and number): Southern Maryland Hosptial
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578 52 1058
6. Sex: XX 1☐ M 2☐ F
7. Age (In yrs. last birthday): 84 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Jan 17, 1916
9. Birthplace (State or Foreign Country): Italy

Usual Residance of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Forestville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6617 Lacona Street
10f. Zip Code: 20747
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Nevar Married 2☐ Married 3XX Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☐ No XX If Yas, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yas 2☐ No XX Specify:
14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 3rd; Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired): Tile Marlble Finisher
16b. Kind of Business/Industry: Commerical Flooring

17. Fathar's Nama (First, Middle, Last): Nicola Fresco
18. Mothar's Nama (First, Middle, Maiden Surnama): Teresa Marino

19a. Informant's Neme/Ralationship (Type, Print): Gino Fresco (SON)
19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code): 6617 Lacona Street, Forestville, Maryland 20747

20a. Mathod of Disposition: XX Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or othar place): Resurrection Masoleum — Jan 11, 2001
20c. Location - City or Town, Stata: Clinton, Maryland

21. Signature of Funeral Service Licensee: ▶ Vust D. Lee Jr
22. Nama and Address of Facility: Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735

Physician /Medical Examiner

23a. Part1. Enter tha diseasa, or complications that caused tha death. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart feilura. List only ona causa on aach lina.

Approximate Intarval Batween Onset and Death

Immediata Causa (Final disaasa or condition resulting in death)
a. End Stage ALS (anterolateral sclerosis) — years.
Due to (or as a consequance of):
b. Possibla sepsis — days
Dua to (or as a consequance of):
Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Diseasa or Injury that initiated events resulting in death) Last
c. Hypoxic encephalopathy — hours
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No
24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yas 2☑ No

25. Was casa referred to medical examinar? 1☐ Yas 2☑ No

26. Place of Death (Check only ona): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☐ Rasidence 6☐ Othar (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, daath occurred at tha time, date and placa, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, data and place, and due to the cause(s) and mannar stated.

29b. Signature and title of cartifier: ▶ Rointan Farahifar M.D.
29c. Licansa number: D43446
29d. Data signed (Month, Day, Year): 1.8.01

30. Nama and address of person who completed cause of daath (Item 23a) (Type, Print): ROINTAN FARAHIFAR MD 9801 Georgia Ave Suit 3-35 Silver Spring MD 20902

State Registrar

31. Data filed (Month, Day, Year): JAN 09 2001
32. Registrar's Signature: Bernice B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Fresco, Angelo #99698

20

Expired 1-7-1 @ 16:30

Dr. Farahifar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 01937

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret Paris (Cook) Freeman
2. Date of Death — Month: Jan. Day: 15, Year: 2001
3. Time of Death: 9:15 AM
4a. Facility Name *(If not institution, give street and number)*: Avalon Manor Health Care Center
4b. City, Town, or Location of Death: Hagerstown, MD
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 217 28 1352
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 93 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: 8/14/1907
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Washington
10c. City, Town or Location: Hagerstown, MD 21740
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 14014 Marsh Pike
10f. Zip Code: 21740
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black
15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondery (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry:
17. Father's Name *(First, Middle, Last)*: William Cook
18. Mother's Name *(First, Middle, Maiden Surname)*: Emma Cook
19a. Informant's Name/Raletionship *(Type, Print)*: Russell N. Freeman (son)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 61 Randolph Ave. Apt. #2 Hagerstown, MD
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Rose Hill Cemetery — Date: 1/19.01
20c. Location - City or Town, Stete: Hagerstown, MD.
21. Signeture of Funeral Service Licensee: ▶ Mary Watson
22. Name and Address of Facility: Watson Funeral Home 24 W. Bethel St., Hagerstown, MD 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediete Cause (Final disease or condition resulting in death)	a. Renal Failure	8 weeks
Due to (or as a consequence of):	b. Diabetise mellitus	years
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Diseese or injury that intieted events rasulting in death) Last	c.	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Stroke; Dementia; High Blood Pressure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)* — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the bast of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and menner steted.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D44996
29d. Date signed *(Month, Day, Year)*: January 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. ZAFAR MALIK 20311 LAPPANS ROAD BOONESBORO, MD 21713

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 17 2001
32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Freeman, Margaret 1-15-01 9:15 AM

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01938

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: James A. Farmer
2. Date of Death (Month, Day, Year): January 4, 2001
3. Time of Death: 18:10pm
4a. Facility Name *(If not institution, give street and number)*: 2809 Lakehurst Ave.
4b. City, Town, or Location of Death: District Heights
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 218-24-6642
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 70 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 5, 1930
9. Birthplace *(State or Foreign Country)*: Charles Cty.Md.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: District Heights
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2809 Lakehurst Ave.
10f. Zip Code: 20747
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 7/16/48 - 9/10/54
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Maintenance Engineer
16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Joseph Farmer
18. Mother's Name *(First, Middle, Maiden Surname)*: Victoria Campbell

19a. Informant's Name/Relationship *(Type, Print)*: Clara Farmer/Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2809 Lakehurst Ave. District Heights, Md. 20747

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland State Veterans
Date: 1/10/01
20c. Location - City or Town, State: Cheltenham, Md.

21. Signature of Funeral Service Licensee: Kurtis A. Jones MD1075
22. Name and Address of Facility: Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pancreatic Carcinoma — 3 mths.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sunny Virchabrani M.D.
29c. License number: D0055403
29d. Date signed *(Month, Day, Year)*: 1/09/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 7610 Carroll Ave. Takoma Park, Md. 20912

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

5

1 VS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01939

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy M. Ford
2. Date of Death Month Day Year: January 16, 2001
3. Time of Death: 7:30 am
4a. Facility Name (If not institution, give street and number): Mariner Health Of Southern Maryland
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 578-38-3282
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 7, 1923
9. Birthplace (State or Foreign Country): Maryland

Usual Residance of Dacedant

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Waldorf
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 14361 Poplar Hill RD
10f. Zip Coda: 20601
10g. Citizan of What Country?: U.S.A

11. Marital Status: 1☒Navar Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐Yas 2☒No If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐Yas 2☒No Specify:
14. Race - Amarican Indian, Black, White, atc. Specify: Black

15. Decedent's Education (Specify only highast grada completed): Elamantary/Secondary (0-12): 12 | Collaga (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Homemaker
16b. Kind of Businass/Industry: Domestic

17. Fathar's Nama (First, Middla, Last): James Ford
18. Mothar's Nama (First, Middla, Maiden Surnama): Eunia Greenfield

19a. Informant's Name/Ralationship (Type, Print): James Makle/Son
19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 13309 Reid Ln. Fort Washington Maryland 20744

20a. Mathod of Disposition: 1☒Burial 2☐Cramation 3☐Ramoval from Stata 4☐Donation 5☐Othar (Specify)
20b. Placa of Disposition (Nama of cematary, crematory or othar placa): St.Peters Cem. Data: 1/20/01
20c. Location - City or Town, Stata: Waldorf Maryland

21. Signature of Funaral Sarvica Licansaa: Lloyd Estep M191
22. Nama and Addrass of Facility: Adams Funeral Home P.A..Aquasco MD 20608

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or hart failure. List only ona causa on aach lina. — Approximata Intarval Batwaan Onsat and Death

Immediata Causa (Final disaasa or condition rasulting in daath):
a. PNEUMONIA
Dua to (or as a consaquanca of):

Saquantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or injury that initiatad avants rasulting in daath) Last:
b.
Dua to (or as a consaquanca of):
c.
Dua to (or as a consaquanca of):
d.

Part II. Other significant conditions contributing to death but not rasulting in tha undarlying causa givan in Part I.: CEREBROVASCULAR ACCIDENT

23b. Did tobacco use contribute to the cause of death? 1☐Yas 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yas 2☒No
24b. Wara autopsy findings available prior to completion of causa of death? 1☐Yas 2☒No

25. Was casa rafarrad to medical examinar? 1☐Yas 2☒No
26. Placa of Death (Check only ona): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Othar: 4☒Nursing Homa 5☐Rasidanca 6☐Othar (Specify)
27. Mannar of Death: 1☒Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Pending invastigation 6☐Could not be datarmined
28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐Yas 2☐No
28d. Dascribe how injury occurrad
28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1☒Certifying Physician: To tha bast of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to the cause(s) and mannar stated.
29b. Signatura and title of cartifiar: MD
29c. Licansa number: D53885
29d. Data signad (Month, Day, Year): 1/16/2001
30. Nama and addrass of parson who completad causa of daath (Item 23a) (Type, Print): VENKAT. S. RAMAVAN 6 POST OFFICE ROAD #101 WALDORF MD 20602

State Registrar

31. Data filad (Month, Day, Year): JAN 17 2001
32. Registrar's Signatura: Donna G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01940

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lenore H. Friedman
2. Date of Death (Month, Day, Year): January 20, 2001
3. Time of Death: 1:40P.

4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 217-28-7990
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct.7,1927
9. Birthplace (State or Foreign Country): Michigan

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 8100 Connecticut Avenue
10f. Zip Code: 20815
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Samuel Heller
18. Mother's Name (First, Middle, Maiden Surname): Dorothy Isberg

19a. Informant's Name/Relationship (Type, Print): Steven Friedman - son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11513 Bedfordshire Ave. Potomac, Maryland 20854

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): King David Memorial Garden
Date: 1/22/2001
20c. Location - City or Town, State: Falls Church,Va.

21. Signature of Funeral Service Licensee: ▶ Donald V Borgwardt
22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediete Cause (Final disease or condition resulting in death)	a. Pneumonia	12 days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Acute Renal Insufficiency

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number. City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to tha cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated.

29b. Signatura and title of certifier: ▶ Gary Fisher MD
29c. License number: D13818
29d. Date signed (Month, Day, Year): 1/20/01

30. Nama end address of person who completed cause of death (Item 23a) (Type, Print): Gary Fisher, M.D. 5530 Wisconsin Avenue, #1443 Chevy Chase, Maryland 20815-4486

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: ▶ Jennie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

LENORE FRIEDMAN ; 01/20/01 ; 1340 PM

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01941

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Donald J. Gray

2. Date of Death (Month, Day, Year): January 3, 2001

3. Time of Death: 0054

4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 240-72-3714

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 53 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 11-15-47

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: DC

10b. County:

10c. City, Town or Location: Washington

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 532 Irving Street, N.W.

10f. Zip Code: 20010

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Rest Room Attendant

16b. Kind of Business/Industry: Club

17. Father's Name *(First, Middle, Last)*: Emual Gray

18. Mother's Name *(First, Middle, Maiden Surname)*: Eloise Debnam

19a. Informant's Name/Relationship *(Type, Print)*: Jacqueline F. Lewis

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6126 Rose Bay Drive; Forestville, Maryland 20747

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Northern Virginia Crematory

Date: 1-9-01

20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: Wanda C. Bacon CCD361

22. Name and Address of Facility: Bacon Funeral Home, Inc. 3447 14th Street, N.W. Washington, D. C. 20010

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Aquired Immune Deficiency Syndrome unknown

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: hepatic failure, congestive heart failure, deep vein thrombosis, encephalopathy

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D41955

29d. Date signed *(Month, Day, Year)*: 01-04-01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Rebecca Elon MD 479 Jumpers Hole Rd Severna Park MD 21146

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001

32. Registrar's Signature: Penny P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit pass.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01942

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Ward Earl Gongoll

2. Deta of Death — Month: January; Dey: 8; Year: 2001

3. Time of Death: 5:40 pm

4a. Facility Nema *(If not institution, give street and number)*: Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Deeth: Montgomery

Funeral Director

5. Sociel Security Number: 360-22-4009

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. lest birthdey)*: 76 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: June 7, 1924

9. Birthplece *(Stete or Foreign Country)*: Minnesota

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: Prince George's

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2400 Queens Chapel Road, #1102

10f. Zip Code: 20782

10g. Citizen of What Country?: U.S.A.

11. Merital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No — If Yas, Give Year or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.): 1☐ Yas 2☒ No *Specify:*

14. Reca - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 5+

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use ratired)*: Librarian

16b. Kind of Business/Industry: Seminary

17. Father's Neme *(First, Middla, Last)*: Alvin Enno Gongoll

18. Mothar's Nama *(First, Middle, Meiden Surneme)*: Arvilla Ruth Knutson

19a. Informent's Neme/Reietionship *(Type, Print)*: Richard A. Gongoll - Brother

19b. Mailing Addrass *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 13386 Riverview Drive, Elk River, MN 55330

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetary, cremetory or othar pieca)*: Becker Cemetery

Dete: 01/16/01

20c. Location - City or Town, Stete: Becker, MN

21. Signature of Funeral Service Licensee: Dorothy Jean Wirt

22. Name end Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disaesa, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heert failure. List only one cause on eech line.

Approximete Intarval Between Onset and Deeth

Immediete Ceuse (Finel disease or condition resulting in deeth):

a. ASPIRATION PNEUMONIA

Due to (or es e consequence of):

b. PREVIOUS JAW RESECTION SURGERY

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disaese or Injury that initiated evants resulting in death) Last

Dua to (or as a consequence of): ? AND DEBILITATED STATE

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

① CARDIAC ARRYTHMIAS, ② CHRONIC OBSTRUCTIVE LUNG DISEASE, ③ CORONARY ARTERY DISEASE, ④ CONGESTIVE HEART FAILURE ⑤ ADRENAL INSUFFICIENCY ⑥ HYPOTHYROID?

23b. Did tobecco use contributa to the causa of death? 1☑ Yaa 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Wes case referrad to medical exeminer? 1☐ Yes 2☑ No

26. Placa of Death *(Check only one)*: Hospitel: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Couid not be determined

28a. Deta of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, daath occurred at the time, date and piece, end dua to the cause(s) end mennar aa stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, deeth occurred at tha time, date and placa, and dua to the cause(s) and manner stated.

29b. Signature and title of certifiar: Mohammed A. Mannan MD

29c. Licanse number: D24593

29d. Dete signed *(Month, Dey, Year)*: 1.8.01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MOHAMMED A. MANNAN MD. 3331-TOLEDO TERRACE HYATTSVILLE, MD. 20782.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001

32. Registrer's Signeture: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01943

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Maria B. Gum

2. Data of Death: Month 1 Day 11 Yaar 2001

3. Tima of Death: 0315

4a. Facility Name (If not institution, give street and number): Gladys Spellman Specialty Hospital

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: PG

Funeral Director

5. Social Security Number: 212 50 9399

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 05/11/16

9. Birthplaca (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Brunswick

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 715 E. Potomac Street

10f. Zip Code: 21716

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Lloyd T. Davis

18. Mother's Name (First, Middle, Maiden Surname): Bessie Marie Guy

19a. Informant's Name/Relationship (Type, Print): Mary Jane Cleary - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6306 63rd Avenue, Riverdale, MD 20737

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Park Heights Cemetery

Date: 01/13/01

20c. Location - City or Town, State: Brunswick, Maryland

21. Signature of Funeral Service Licensee: Allen Smith

22. Nama and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part1. Entar tha disaase, or complications that causad the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death): a. Stroke — Weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia, Adult Respiratory distress syndrome, Congestive heart failure, chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yas 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Homa 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D32261

29d. Date signed (Month, Day, Year): 1-12-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Keith J. Feldman MD 9500 Annapolis Rd, Lanham MD 20706

State Registrar

31. Data filed (Month, Day, Year): JAN 12 2001

32. Registrar's Signature: Sandra G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01944

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Allen Scott Geisler

2. Date of Death (Month, Day, Year): January 14, 2001

3. Time of Death: 10:41 AM

4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 220-78-6240

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 40 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 27, 1960

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Walkersville

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 8606 Imagination Court

10f. Zip Code: 21793

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Personal Care Giver

16b. Kind of Business/Industry: Health Care

17. Father's Name *(First, Middle, Last)*: Lawrence L. Geisler, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Thelma Goins

19a. Informant's Name/Relationship *(Type, Print)*: Ms. Vickie Geisler, Sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8606 Imagination Ct., Walkersville, Md. 21793

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Creagerstown Cemetery, Jan. 17, 2001

20c. Location - City or Town, State: Creagerstown, Md.

21. Signature of Funeral Service Licensee: Richard E. Graf M00255

22. Name and Address of Facility: Keeney and Basford P.A. Funeral Home, 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: H.I.V. ; Cigarette Smoker

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA / Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Andrew Zarick Jr. MD

29c. License number: D35164

29d. Date signed *(Month, Day, Year)*: January 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andrew Zarick, Jr., M.D., 1080 West Patrick Street, Frederick, Maryland 21703

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: Bonnie B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01945

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDWIN G. GRAHAM

2. Date of Death Month Day Year: JANUARY 15, 2001

3. Time of Death: 1:25 PM

4e. Facility Name (If not institution, give street and number): BRIAR MEADOW - 6108 GRANBY ROAD

4b. City, Town, or Location of Death: DERWOOD

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 057 05 5321

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): APRIL 9, 1909

9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: FLORIDA

10b. County: PALM BEACH

10c. City, Town or Location: WEST PALM BEACH

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2683A BARKLEY DRIVE

10f. Zip Code: 33415

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ACCOUNTANT

16b. Kind of Business/Industry: INSURANCE CO.

17. Father's Name (First, Middle, Last): GEORGE GRAHAM

18. Mother's Name (First, Middle, Maiden Surname): MARY HELMUS

19e. Informant's Name/Relationship (Type, Print): GAIL E. DOBENECKER, DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3709 DELLABROOK ST., OLNEY, MD. 20832

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): METROPOLITAN CREMATORY

Date: 1/16/01

20c. Location - City or Town, State: ALEXANDRIA, VA.

21. Signature of Funeral Service Licensee: Muriel H. Barber

22. Name and Address of Facility: MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. URO Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Neurogenic bladder

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Senile DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) GROUP HOME

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible] MD

29c. License number: D 27786

29d. Date signed (Month, Day, Year): JAN 15 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BERNARD J PROUS MD MONT GEN'L HOSP

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: [illegible]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01946

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JAY W. GILLESPIE

2. Date of Death Month / Day / Year: JANUARY 12 2001

3. Time of Death: 12:30 AM

4a Facility Name *(If not institution, give street and number)*: 6001 Muncaster Mill Road - Casey House

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 223-30-0017

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 28 1925

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Laytonsville

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 21510 Laytonsville Road

10f. Zip Code: 20882

10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Detes:

13. Was Decedeni of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 3 / College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use ratired)*: Farmer

16b. Kind of Business/Industry: Farming

17. Father's Name *(First, Middle, Last)*: Buford Gillespie

18. Mother's Neme *(First, Middle, Maiden Surname)*: Tina Alley

19a. Intormant's Name/Reletionshlp *(Type, Print)*: Ann Gillespie / Daughter

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 21510 Laytonsville Road, Laytonsville, Md. 20882

20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removel from Stete 4☐Donetion 5☐Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: True Gospel Cemetery

Date: 1/17/01

20c. Location - City or Town, Stata: Lisbon, Maryland

21. Signature of Funeral Service Licensee: ▶ Muriel H. Barber

22. Name and Address of Facility: Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Maryland 20882

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. Lisi only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC CARCINOMA — 4 months

Due to (or as a consequence ot):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. LUNG CANCER — 5 months

Due to (or as e consequenca of):

c.

Due lo (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the causa of death? 1☐Yaa 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy tindings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other *(Specify)* Hospice

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time ot Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and menner es stated. 2☐**Medical Examiner**: On the besis of exeminetion and/or investigation, in my opinion, death occurred at the tima, date and placa, and due to the cause(s) and manner stated.

29b. Signeture end litle of certifier: ▶ E. P. Libre MD.

29c. License number: D09470

29d. Date signed *(Month, Day, Year)*: January 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Eugene P. Libre, M.D. 10400 Connecticut Ave., Kensington, Md. 20895

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signeture: ▶ Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01947

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: PEARL BAILEY GAITHER

2. Date of Death (Month, Day, Year): JAN. 15, 2001

3. Time of Death: 5:00 am

4a. Facility Name *(If not institution, give street and number)*: Calvert County Nursing Center

4b. City, Town, or Location of Death: Pr. Frederick

4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 577-38-8784

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 10/30/1929

9. Birthplace *(State or Foreign Country)*: Wash., D.C.

Usual Residence of Decedent

10a. State: MD

10b. County: Calvert

10c. City, Town or Location: Prince Frederick

10d. Inside City Limits: ☒ Yes 2☐ No

10e. Street and Number: 470 West Dares Beach Road #101

10f. Zip Code: 20678

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Hanson Bailey

18. Mother's Name *(First, Middle, Maiden Surname)*: Mildred Shipman

19a. Informant's Name/Relationship *(Type, Print)*: Samantha St. John/daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6381 Mill Branch Road, Huntingtown, MD

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: So. Memorial Gardens

Date: 1/17/01

20c. Location - City or Town, State: Dunkirk, MD

21. Signature of Funeral Service Licensee: C. Wood

22. Name and Address of Facility: Raymond-Wood F.H., P.A. POB 430, Dunkirk, MD 20754

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARREST

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

b. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

c. RENAL FAILURE

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D55027

29d. Date signed *(Month, Day, Year)*: January 15th, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR MANOJ PANWALA 110 Hosp. Road, Suite 303 Pr Frederick, MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01948

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Brigitte Geraci

2. Date of Death (Month, Day, Year): January 11, 2001

3. Time of Death: 2:30 AM

4a. Facility Name *(If not institution, give street and number)*: 231 Welch Way

4b. City, Town, or Location of Death: Lothian

4c. County of Death: Anne Arundel Co.

Funeral Director

5. Social Security Number: 216-58-6810

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: November 5, 1938

9. Birthplace *(State or Foreign Country)*: Germany

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel Co.

10c. City, Town or Location: Lothian

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 231 Welch Way

10f. Zip Code: 20711-9410

10g. Citizen of What Country?: Germany

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Waitress

16b. Kind of Business/Industry: Restraunt

17. Father's Name *(First, Middle, Last)*: Bernhard Surmann

18. Mother's Name *(First, Middle, Maiden Surname)*: Annaliese Schlaak

19a. Informant's Name/Relationship *(Type, Print)*: Robert Finsterwalder (Son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2130 Arbour Walk Circle, Apt.#2712, Naples, FL34109

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lee Crematory | Date: Jan. 12, 2001

20c. Location - City or Town, State: Clinton, MD

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Lee Funeral Home Calvert, P.A. 8125 Southern Maryland Blvd. Owings, MD 20736

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HEPATOCELLULAR CARCINOMA — 3 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. HEPATIC CIRRHOSIS

Due to (or as a consequence of):

c. ALCOHOLISM

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ [signature] JOHN H. WEIGEL, M.D.

29c. License number: D26358

29d. Date signed *(Month, Day, Year)*: JAN. 11. 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN H. WEIGEL, M.D. - PRINCE FREDERICK, MD-20678

10

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001

32. Registrar's Signature ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01949

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILLIAM EVERET GREENE
2. Date of Death (Month, Day, Year): January 11, 2001
3. Time of Death: 11:45 PM
4a. Facility Name *(If not institution, give street and number)*: Homewood at Williamsport
4b. City, Town, or Location of Death: Williamsport
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214-09-2705
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 82 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Date of Birth *(Month, Day, Year)*: Feb. 5, 1918
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Washington Co.
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 1040 View Street
10f. Zip Code: 21740
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 2
18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Accountant
16b. Kind of Business/Industry: Furniture Company

17. Father's Name *(First, Middle, Last)*: William E. Greene, Sr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Grace Lee Swink

19a. Informant's Name/Relationship *(Type, Print)*: Barbara L. Stouffer/Sis/In-Law
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1603 Mt. Aetna Road, Hagerstown, Maryland 21740

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rest Haven Cemetery
Date: Jan. 16
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Kelly C. Zinn
22. Name and Address of Facility: Douglas A. Fiery Funeral Home 1331 Eastern Blvd.,N.,Hagerstown,Maryland 21642

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the *mode* of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — days
Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to *immediate* cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last:
b. Due to (or es e consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying ceuse given in Pert I.

Hypertension
Diabetes Mellitus Type II
Arteriosclerosis

23b. Did tobacco uee contribute to the cauee of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24e. Was en autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to *medical* examiner? 1☐Yes 2☒No
26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end piece, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigetion, in *my* opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signeture end title of certifier: [signature] MD
29c. License number: D26806
29d. Date signed *(Month, Day, Year)*: January 12, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): MD: NMD 747 Northern Ave Hagerstown MD 21742

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

1-11-01 11:45 pm

William E. Greene Jr.

01-0008-033
JASON HIGGINS
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01950

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jason Higgins
2. Date of Death: Month JANUARY Day 01 Year 2001
3. Time of Death: 0407 AM
4a. Facility Name (If not institution, give street and number): LAUREL REGIONAL HOSPITAL
4b. City, Town, or Location of Death: LAUREL
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 218-04-4068
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 27 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-5-1973
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Beltsville
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3802 Calverton Blvd #16
10f. Zip Code: 20705
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 3yrs
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Entrepreneur
16b. Kind of Business/Industry: Private
17. Father's Name (First, Middle, Last): Egbert Augustus Higgins
18. Mother's Name (First, Middle, Maiden Surname): Edna C. Barnett
19a. Informant's Name/Relationship (Type, Print): Egbert Augustus Higgins/Father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12403 Ronald Beall RD Upper Marlboro, MD 20774
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Mt. Olivet Cemetery
Date: 1-6-2001
20c. Location - City or Town, State: Washington, DC
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd Landover, MD 20785

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple Gunshot Wounds
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No
25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year): 1-1-01
28b. Time of Injury: 0350 M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Subject Shot
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Street
28f. Location (Street and Number or Rural Route Number, City or Town, State): 4040 Pendermill Rd
29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): JANUARY 01, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001
32. Registrar's Signature: [signature] S. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

CR

(20)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01951

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Willa P. Hodge
2. Date of Death (Month, Day, Year): JANUARY 04, 2001
3. Time of Death: 09:02 P.M.
4a. Facility Name (If not institution, give street and number): MALCOLM GROW MEDICAL CENTER
4b. City, Town, or Location of Death: CAMP SPRINGS
4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 577-28-6796
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11/27/19
9. Birthplace (State or Foreign Country): Balt.,Md.

Usual Residence of Decedent

10a. State: D.C.
10b. County: N/A
10c. City, Town or Location: Washington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4709 Dix St.,N.E.
10f. Zip Code: 20019
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 1 yr.
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress
16b. Kind of Business/Industry: Tailoring

17. Father's Name (First, Middle, Last): Walter J. Pickett
18. Mother's Name (First, Middle, Maiden Surname): Mary C. McCormick

19a. Informant's Name/Relationship (Type, Print): Florence Weaver/Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7428 Quail Ridge Ln.,Bowie,Md. 20720

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Mem. Park | Date: 1/9/01
20c. Location - City or Town, State: Landover, Md.

21. Signature of Funeral Service Licensee: Darry W. Pratt
22. Name and Address of Facility: H.S.Washington & Sons Co.,Inc. 4925 Burroughs Ave.,N.E.,Wash.,D.C. 20019

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. UROSEPSIS-SEPTIC SHOCK	ONE DAY
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ALZHEIMERS DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier:
29c. Licensa number: ME70064
29d. Date signed (Month, Day, Year): 1/6/01

30. Name and address of person who completed cause of death (item 23a) (Type, Print): PEDRO A. ALONSO, MAJ, USAF, MC
89 MDG/1050 W. PERIMETER RD. ANDREWS AIR FORCE BASE, MD 20762-6600

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001
32. Registrar's Signature: George B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

NAME: WILLA HODGE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01952

NAME: WILLIAM HIGGINS

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Francis Higgins

2. Data of Death Month / Day / Year: JANUARY 5 2001

3. Time of Death: 1220 AM

4a. Facility Name *(If not institution, give street and number)*: NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 217-03-7010

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Aug. 2, 1916

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Anne Arundel

10c. City, Town or Location: Crofton

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1493 Crofton Parkway

10f. Zip Code: 21114

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 6

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Attorney

16b. Kind of Business/Industry: Law

17. Father's Name *(First, Middle, Last)*: Claggett Higgins

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Wachter

19a. Informant's Name/Relationship *(Type, Print)*: Susan McDonald daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1493 Crofton Pkwy., Crofton, Md. 21114

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory Date: 01-06-01

20c. Location - City or Town, State: Alexandria, VA.

21. Signature of Funeral Service Licensee: Beall

22. Name and Address of Facility: Beall Funeral Home, 6512 N.W. Crain Hwy., Bowie, Md. 20715

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. *(Approximate Interval Between Onset and Death)*

Immediate Cause (Final disease or condition resulting in death): a. SEPSIS

Due to (or as a consequence of): b. GASTROINTESTINAL BLEEDING

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury | 28c. Injury at Work? 1 [ ] Yes 2 [ ] No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: B Onabajo MD

29c. License number: D45149

29d. Data signed *(Month, Day, Year)*: JANUARY 5 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ONABAJO. B 301 HOSPITAL DRIVE GLEN BURNIE MD 21061

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 09 2001

32. Registrar's Signature: Jenna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

(12)

Aaron M. Howard
00
01-0007-033
UNK -002
ASP

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01953

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Aaron Marteze Howard
2. Date of Death — Month: JANUARY Day: 01 Year: 2001
3. Time of Death: 0340
4e. Facility Name *(If not institution, give street and number)*: 4040 POWDERMILL RD.
4b. City, Town, or Location of Death: Calverton
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 579 98 5204
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 27 Yrs.
If Under 1 Year — Months: Days:
If Under 24 Hrs. — Hours: Min.:
8. Date of Birth *(Month, Day, Year)*: 11/8/73
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Clinton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 8208 Temple Hill Rd.
10f. Zip Code: 20735
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 12th — College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Security
16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Aaron Howard
18. Mother's Name *(First, Middle, Maiden Surname)*: Ernestine Willis

19a. Informant's Name/Relationship *(Type, Print)*: Ernestine Howard/mother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8208 Temple Hill Rd. Clinton MD 20735

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Harmony Cemtery
Date: 1/8/01
20c. Location - City or Town, State: Landover, MD

21. Signature of Funeral Service Licensee: John T Bohl
22. Name and Address of Facility: Robert G. Mason Funeral Home, 1661 Good Hope Rd. SE Washington, DC 20020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death): a. Multiple Gunshot Wounds

Due to (or es a consequence of):

Sequentially lisi conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequenca of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* SCENE

27. Menner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☒ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*: 1-1-01
28b. Time of Injury: 0332 M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Subject Shot
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Street
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 4040 Powdermill Rd

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated. 2☒ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, dete end piace, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier:
29c. License number: O.C.M.E
29d. Date signed *(Month, Day, Year)*: JANUARY 01, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): David R Fowler, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 10 2001
32. Registrar's Signature: Barbara D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01954

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Nellie Hawkins
2. Date of Death Month Day Year: January 7, 2001
3. Time of Death: 10:00am
4a. Facility Name *(If not institution, give street and number)*: Southern Maryland Hospital
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 578-30-2454
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug 4, 1926
9. Birthplace *(State or Foreign Country)*: Washington Dc

3 1/2

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Oxon Hill
10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 5926 Shoshone Dr
10f. Zip Code: 20745
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Supervisor
16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Warren Bracey
18. Mother's Name *(First, Middle, Maiden Surname)*: Ida Stone

19a. Informant's Name/Relationship *(Type, Print)*: Elaine Renwick / Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5926 Shoshone Dr, Oxon Hill, Md 20745

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lincoln Memorial Cem
Date: 1-13-01
20c. Location - City or Town, State: SUITLAND, MD

21. Signature of Funeral Service Licensee: ▶ Ruth A. Stringer 101085
22. Name and Address of Facility: Alexander S. Pope Funeral Home, 2617 Penn. Ave S.E. Washington Dc 20020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. cardiopulmonary arrest
Due to (or as a consequence of):
b. coronary artery disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

systemic lupus erythematosus
severe muscle atrophy & decompensation
multiple decubitus ulcers

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Valerie T. Custer MD
29c. License number: D15984
29d. Date signed *(Month, Day, Year)*: 1/7/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Custer 7503 Surratts rd, Clinton, md

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001
32. Registrar's Signature: G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

(3)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01955

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rose L. Hill
2. Date of Death (Month, Day, Year): January 11, 2001
3. Time of Death: 8:55AM
4a. Facility Name (If not institution, give street and number): Pineview Nursing&Rehab. center
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-16-3518
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 1,1920
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Clinton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9106 Pineview Lane
10f. Zip Code: 20735
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 11th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: At Home

17. Father's Name (First, Middle, Last): Everett Kershner
18. Mother's Name (First, Middle, Maiden Surname): Hallie Ruth Kellison

19a. Informant's Name/Relationship (Type, Print): Sandra Chinn/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1691 Bent Tree Trail Ocean Isle Beach, N.C.28469

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington National Cem.
Date: 1/18/01
20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: George P. Kalas
22. Name and Address of Facility: George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745

CR

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Cardiac arrythmia	12 hr
Due to (or as a consequence of): b.	Atrial fibrillation Coronary Atg	4h
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	disease	
Due to (or as a consequence of): d.	old Cerebro Vascular	4h

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD Attending
29c. License number: D-24535
29d. Date signed (Month, Day, Year): 01.11.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Laxmi Berwa, M.D. 7701 Old Branch Ave. Clinton, Md. 20735

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001
32. Registrar's Signature: Geneva B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

(3)

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended item#23per MD 01/18/2001 FCH **Certificate of Death** KS

Reg. No. 2001 01956

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month	Day	Year	3. Tima of Death
NELLIE VIRGINIA HARTMAN	JANUARY	8,	2001	1:50 AM

4a Facility Nama (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sax	7. Aga (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplaca (State or Foreign Country)
228-07-2703	1☐ M 2☒ F	81 Yrs.			Jan. 18, 1919	Maryland

Usual Residence of Decedent

10a. Stata	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Knoxville	1☐ Yas 2☒ No

10e. Street and Number	10f. Zip Coda	10g. Citizan of What Country?
3642 Petersville Road	21758	U.S.A.

11. Marital Status	12. Was Decadant Evar in U.S. Armad Forcas?	13. Was Decedent of Hispanic Origin? (Specify Yaa or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.)	14. Race - Amarican Indian, Black, White, atc.
1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:	1☐ Yas 2☒ No Specify:	Specify: White

15. Decadant's Education (Specify only highest grade completed)		16a. Decadant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	Collega (1-4or 5+)		
11		Loan Officer	Bank

17. Father's Nama (First, Middle, Last)	18. Mother's Nama (First, Middle, Maiden Surname)
Elias Kidwiler	Marie Smith

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Carol Ann Rowe (Daughter)	3874 Shadywood Drive #13, Jefferson, Maryland 21755

20a. Mathod of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Data	20c. Location - City or Town, State
1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)	Smithsburg Crematory	1/8/01	Smithsburg, Maryland

21. Signature of Funeral Service Licensee: Robert E. Dailey Jr.

22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach line.

		Approximata Interval Batwaan Onset and Death
Immediata Causa (Final disaasa or condition resulting in death) a.	~~Pneumonia~~ Aspiration Pneumonia	2 weeks
Due to (or as a consequence of): b.	~~Aspiration~~	~~2 weeks~~
Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disease or injury that initiated avants rasulting in death) Last: Due to (or as a consequanca of): c.		
Due to (or as a consequanca of): d.		

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

Severe prerenal azotemia, persisting in Spite of Volume overload. Duodenal ulcer with gastrointestinal bleeding

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☐ Rasidence 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined

28a. Date of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
	M	1☐ Yas 2☐ No	

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifiar (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, daath occurrad at the time, date and place, and due to tha cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha time, data and place, and due to tha causa(s) and mannar stated.

29b. Signatura and title of certifier	29c. Licensa number	29d. Data signed (Month, Day, Year)
Kathleen W Stern MD	D32073	1/8/01

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): Kathleen W. Stern MD, 610 Ninth Ave, Brunswick, Md. 21716

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signatura
JAN 09 2001	Geneva B Hawks

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ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

#23

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01957

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Phyllis Kate Hodge
2. Date of Death: Month January Day 9 Year 2001
3. Time of Death: 6:13 AM
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 218-42-6512
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 1, 1912
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7407 Willow Road
10f. Zip Code: 21702
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Giva Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: Education

17. Fathar's Nama (First, Middle, Last): Philip O.E. Brooks
18. Mother's Name (First, Middle, Meiden Sumema): Virginia L. Frink

19a. Informant's Name/Relationship (Type, Print): Charles A. Hodge
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 427 Poplar Springs Drive, Killen, Alabama 35645

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)
20b. Placa of Disposition (Neme of cemetery, cremetory or other piece): Smithsburg Crematory
Date: 1/10/2001
20c. Location - City or Town, Stata: Smithsburg, Maryland

21. Signature of Funaral Service Licensee: ▶ P. Ryan McMillian
22. Nama and Addrass of Facility: 106 East Church St. Keeney and Basford P.A. Funeral Home Frederick, MD 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	ASYSTOLE	30 min
Due to (or as a consequence of): b.	ACUTE MYOCARDIAL INFARCTION	30 min
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last — Due to (or as a consequence of): c.	ARTERIOSCLEROTIC CARDIO-VASCULAR DIS.	UNKNOWN
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ALZHEIMERS DISEASE

23b. Did tobacco use contributa to the causa of death? 1☐ Yas 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certifiar: ▶ Geo. I. Smith, M.D. VPMA
29c. Licensa number: D10587
29d. Data signad (Month, Dey, Year): 1/10/01

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): GEORGE I. SMITH, M.D. VICE-PRES MED AFFAIRS FREDERICK MEM. HOSP FREDERICK, MD. 21701

State Registrar

31. Date filed (Month, Dey, Year): JAN 11 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01958

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY L. HYATT
2. Date of Death (Month, Day, Year): January 10, 2001
3. Time of Death: 7:00 PM
4a. Facility Name (If not institution, give street and number): 201 Bennett Court
4b. City, Town, or Location of Death: Thurmont
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 219-03-0826
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 28, 1919
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Thurmont
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 201 Bennett Court
10f. Zip Code: 21788
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner
16b. Kind of Business/Industry: Grocery Business

17. Father's Name (First, Middle, Last): William H. Martin
18. Mother's Name (First, Middle, Maiden Surname): Mary C. Sherfey

19a. Informant's Name/Relationship (Type, Print): Betty L. Carwithen (Niece)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 201 Bennett Court, Thurmont, Maryland 21788

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Mount Olivet Cemetery
Date: 1/13/01
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Robert E. Dailey Jr.
22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MD 21788

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. obstruction } product — 1 week

Due to (or as a consequence of):
b. extensive pancreatic carcinoma

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
h/o colon cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D14C2C
29d. Date signed (Month, Day, Year): Jan 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): P. Gregory Rausch, MD 501 West 7th Street, Frederick, Maryland 21701

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001
32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01959

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BROOKS WARREN HART
2. Date of Death (Month, Day, Year): January 12, 2001
3. Time of Death: 0315
4a. Facility Name (If not institution, give street and number): 10818 Oak Valley Drive
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington County

Funeral Director

5. Social Security Number: 219-05-9913
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 1, 1920
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Washington Co.
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10818 Oak Valley Drive
10f. Zip Code: 21740
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Brakeman Conductor
16b. Kind of Business/Industry: Railroad

17. Father's Name (First, Middle, Last): Daniel Webster Hart
18. Mother's Name (First, Middle, Maiden Surname): Nora E. Kidney

19a. Informant's Name/Relationship (Type, Print): Ernestine B. Hart/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10818 Oak Valley Drive, Hagerstown, Maryland 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sphors Crossroads U.M. Church Cemetery
Date: Jan. 15
20c. Location - City or Town, State: Berkeley Springs, WV

21. Signature of Funeral Service Licensee: Tilley A Zinn
22. Name and Address of Facility: Douglas A. Fiery Funeral Home 1331 Eastern Blvd.,N.,Hagerstown,Maryland 21742

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Chronic Lymphocytic leukemia
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Coronary artery disease; peptic ulcer disease; abdominal aneurysm.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Mary E. Money M.D.
29c. License number: D23815
29d. Date signed (Month, Day, Year): 1/15/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 354 Mill St. Hag. Md 21740 Dr. MARY Money

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01960

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Francis HOLLAND
2. Date of Death (Month, Day, Year): January 14, 2001
3. Time of Death: 7 55 Am

4a. Facility Name (If not Institution, give street and number): 300 Northern Avenue
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 084-18-6203
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 7, 1927
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 300 NOrthern Avenue
10f. Zip Code: 21742
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: W.W. II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 0-11 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): brakeman
16b. Kind of Business/Industry: railroad

17. Father's Name (First, Middle, Last): Patrick Francis Holland
18. Mother's Name (First, Middle, Maiden Surname): Anges unknown Schwartz

19a. Informant's Name/Relationship (Type, Print): Mrs. Linda H. DeCola - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 806 G College Lane, Salisbury, Maryland 21804

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Cedar Lawn Memorial Park
Date: Jan. 17, 2001
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott M Minnich
22. Name and Address of Facility: Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lung Cancer — 20 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or Investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael J. McCormick M.D.
29c. License number: 041667
29d. Date signed (Month, Day, Year): 1-15-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael McCormick 11110 Medical Campus Hagerstown MD 21742

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01961

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alfred Clarence HILL
2. Date of Death (Month, Day, Year): January 14, 2001
3. Time of Death: 8AM
4a. Facility Name (If not institution, give street and number): 10815 Coffman Avenue
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 556-05-8865
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 23, 1914
9. Birthplace (State or Foreign Country): Utah

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 10815 Coffman Avenue
10f. Zip Code: 21740
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): owner and operator
16b. Kind of Business/Industry: Painting and Wallcovering

17. Father's Name (First, Middle, Last): unknown Hill
18. Mother's Name (First, Middle, Maiden Surname): Charlotte unknown

19a. Informant's Name/Relationship (Type, Print): Harold Hill - son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10815 Coffman Ave., Hagerstown, Md. 21740

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hagerstown Crematory
Date: 1-18-01
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Anemia	5 months
Due to (or as a consequence of):	b. Iron Deficiency	5 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. Polyarteritis Nodosa	5 months
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year): .01
28b. Time of Injury: M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D0056413
29d. Date signed (Month, Day, Year): 1/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sanjay Saxena, M.D., 3 Byrkit Dr., Williamsport, Md. 21795

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended
Line 5./WCHD/SC
1-18-01

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01962

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RUBY VIOLA HOSE

2. Date of Death (Month, Day, Year): January 15, 2001

3. Time of Death: 2:45 A.M.

4a. Facility Name (If not institution, give street and number): Williamsport Nursing Home

4b. City, Town, or Location of Death: Williamsport

4c. County of Death: Washington

Funeral Director

5. Social Security Number: ~~220-34-0980~~ 214-09-1529

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 28, 1909

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Williamsport

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 154 North Artizan Street

10f. Zip Code: 21795

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Emerson Hose

18. Mother's Name (First, Middle, Maiden Surname): Carrie Sprankle

19a. Informant's Name/Relationship (Type, Print): Anne D. Hose Sister In Law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16106 Selva Drive, San Diego, CA. 92128

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematorium

Date: 01-19-2001

20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: ▶ R. Noel Brady

22. Name and Address of Facility: Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Recurrent Anaemia due to Dyplastic Syndrome Appr 1 yr

Due to (or as e consequence ot):

b. Lethargy, advanced age. 2-3 Days.

Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last

Due to (or as a consequence of):

c. Failure to thrive. Appr 1 yr.

Dua to (or as a consequence of):

d. Dementia - Alzheimers. Appr 5 yrs.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy tindings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examinar? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ H Qadir MD

29c. Licensa number: D46561

29d. Date signed (Month, Day, Year): JAN. 15, 2001

30. Name and address of person who completed ceuse ot death (Item 23a) (Type, Print): Ghazala Qadir M.D. 20311 Lappans Road, Boonsboro, Md. 21713

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

January, 15, 2001 @ 2:45 AM

Ruby Viola Hose

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 01963

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary L. Hagens
2. Date of Death Month Day Year: January 14, 2001
3. Time of Death: 9:48AM
4a. Facility Name *(If not institution, give street and number)*: 3006 Gallery Place- Apartment 13
4b. City, Town, or Location of Death: Waldorf
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 214-48-8214
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 73 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: November 30, 27
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Waldorf
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3006 Gallery Place Apt.13
10f. Zip Code: 20602
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Domestic

17. Father's Name *(First, Middle, Last)*: Francis Makle
18. Mother's Name *(First, Middle, Maiden Surname)*: Ella CHapman

19a. Informant's Name/Raletionship *(Type, Print)*: Charles E. Hagens/Son
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 13048 State RoadKing George Va. 22485

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: St.Peters Cemetery
Date: 1/19/01
20c. Location - City or Town, Stafe: Waldorf Maryland

21. Signature of Funeral Service Licensee: [signature] M191
22. Name and Address of Facility: Adams Funeral Home P.A. Aquasco MD 20608

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that ceused the death. Do not enter the moda of dying, such as cerdiac or respiratory errest, shock, or heart failure. List *only one* ceuse *on* each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)
a. Uterine Cancer
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying ceusa given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Streat and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end menner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated.

29b. Signatura and fitle of certifier: [signature]
29c. Licansa number: D28352
29d. Date signed *(Month, Day, Year)*: January 15, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Krishan Mathur, MD P.O. Box 1703, La Plata, MD 20646

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01964

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Elsie Catherine Jackson

2. Date of Death — Month: January; Day: 6; Year: 2001

3. Time of Death: 8:15AM

4a. Facility Name *(If not institution, give street and number)*: 6916 Standish Drive

4b. City, Town, or Location of Death: Hyattsville

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-42-0986

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 69 Yrs.

If Under 1 Year — Months: ; Days: ; If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: Dec. 9, 1931

9. Birthplace *(State or Foreign Country)*: Wash., D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6916 Standish Drive

10f. Zip Code: 20784

10g. Citizen of What Country?: United States

11. Meritel Sfetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Computer Technician

16b. Kind of Business/Industry: Government

17. Father's Name *(First, Middle, Last)*: Herbert Palmer

18. Mother's Name *(First, Middle, Maiden Sumame)*: Cleophia Talley

19a. Informant's Name/Relationship *(Type, Print)*: Yvette Cashwell - Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7320 Carroll Ave., Takoma Park, MD 20912

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cedar Hill Cemetery

Date: 1/12/2001

20c. Location - City or Town, State: Suitland, MD

21. Signature of Funeral Service Licensee: John T. Stewart, III

22. Name and Address of Facility: Stewart Funeral Home, 4001 Benning Rd., N.E. Wash., D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death) a. Lung Carcinoma — 1yr

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** confributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

28. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: K Lee

29c. License number: D27521

29d. Dete signed *(Month, Day, Year)*: Jan 12, 01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): KADIE LEACH M.D 9500 ANNAPOLIS Rd AI LANHAM, Md 20706

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001

32. Registrer's Signeture: Geneva G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

25

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01965

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Shirley Eithera Jolly
2. Date of Death Month / Day / Year: January 10, 2001
3. Time of Death: 7:24 AM
4e. Facility Name *(If not institution, give street and number)*: 3111 Reiner Court
4b. City, Town, or Location of Death: Temple Hills
4c. County of Death: Prince George's Co.

Funeral Director

5. Social Security Number: 578-52-5401
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 63 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 21, 1937
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: D.C.
10b. County: N/A
10c. City, Town or Location: Washington, D.C.
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 900 G Street, N.E. #718
10f. Zip Code: 20001
10g. Citizen of Whet Country?: United States America

11. Meritel Stetus: 1☐ Never Merried 2☐ Married 3☐ Widowed 4☒ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indien, Bleck, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 11th; College (1-4or 5+):
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Custodial
16b. Kind of Business/Industry: D.C. Government

17. Fether's Neme *(First, Middle, Last)*: Not Available
18. Mother's Name *(First, Middle, Maiden Surname)*: Helen Thomas

19e. Informent's Neme/Reletionship *(Type, Print)*: Randolph A. Thomas (Son)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 139 Cree Drive; Oxon Hill, Maryland 20745

20e. Method of Disposition: ☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Lincoln Cemetery — Dete: 1/16/01
20c. Location - City or Town, Stete: Suitland, Maryland

21. Signeture of Funeral Services Licensee: Glenda M. Freeman
22. Neme end Address of Feciility: Robert O. Freeman Funeral Services, Inc. 1353 H Street, N.E. ; Washington, D.C. 20002

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on eech line. — Approximate Intervel Between Onset end Deeth

Immediate Ceuse (Finel diseese or condition resulting in deeth): e. Metastatic Pancreas Cancer
Due to (or es e consequence of):
Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in death) Lest:
b. Due to (or es e consequence of):
c. Due to (or es e consequence of):
d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No
26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Hospice

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred et the time, dete end piece, and due to the cause(s) end menner steted.
29b. Signeture end title of certifier:
29c. License number: DC 19655
29d. Dete signed *(Month, Dey, Year)*: 1/12/01
30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): John Marshall, M.D.; 3800 Reservoir Road, N.W. Washington, D.C. 20007

State Registrar

31. Dete filed *(Month, Dey, Year)*: JAN 12 2001
32. Registrer's Signeture: Sandra B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01966

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Guy Newton Johnson
2. Date of Death Month Day Year: January 13, 2001
3. Time of Death: 4:28 PM
4a. Facility Name *(If not institution, give street end number)*: Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 213-24-3004
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Yeer)*: Sept. 27, 1923
9. Birthplace *(Stete or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. Stata: Maryland
10b. County: Montgomery
10c. City, Town or Location: Damascus
10d. Inside City Limits: 1 [ ] Yas 2 [X] No
10e. Street and Number: 11205 Mt. View Road
10f. Zip Code: 20872
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highast grede completed)*: Elementery/Secondery (0-12): 11 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Truck Driver
16b. Kind of Business/Industry: Cement Company
17. Father's Name *(First, Middle, Last)*: William E. Johnson
18. Mother's Name *(First, Middle, Maiden Sumame)*: Gertrude C. Poole
19a. Informant's Name/Relationship *(Type, Print)*: Gloria D. Johnson - Wife
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 11205 Mt. View Road, Damascus, Maryland 20872
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Ramoval from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, crematory or othar piece)*: Mr. View Cemetery
Date: 1/18/01
20c. Location - City or Town, State: Damascus, Maryland
21. Signature of Funeral Service Licensee: Olin L. Molesworth
22. Nama and Address of Facility: Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death): a. Acute Myocardial infarction — 1 Day

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consaquenca of):
d.

Part II. **Other significant conditions** contributing to daath but not rasulting in tha underlying cause given in Part I.: Diabetes Mellitus, Congestive Heart Failure, Chronic Renal Failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of causa of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Piece of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as steted. 2 [ ] **Medical Examiner**: On the basis of exeminetion and/or investigation, In my opinion, death occurred at the time, date and place, and due to the ceuse(s) and mannar stated.

29b. Signature and title of certifier: Barry Hecht
29c. License number: 019192
29d. Data signad *(Month, Day, Year)*: 01/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BARRY HECHT, MD 3941 FERRARA DRIVE WHEATON, MD 20906

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01967

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gordon Allen Knopp
2. Date of Death (Month, Day, Year): January 14, 2001
3. Time of Death: 6:45 a.m.
4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 219 40 3966
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 58 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 4, 1942
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Deale
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 920 Main Street
10f. Zip Code: 20751
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrical Inspector
16b. Kind of Business/Industry: sanitary Commission

17. Father's Name (First, Middle, Last): Alrano Knopp
18. Mother's Name (First, Middle, Maiden Surname): Mary Alice Rogers

19a. Informant's Name/Relationship (Type, Print): Evelyn Elaine Knopp (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as 10 a-f

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 1-16-01
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: ▶ Charles F. Bell
22. Name and Address of Facility: Rausch Funeral Home, P.A. P. O. Box # 100, Owings, MD 20736

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CARDIAC DYSRYTHMIA	minutes
Due to (or as a consequence of):	b. Respiratory failure	2 hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): c. COPD	years
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Kari Alperovitz-Bichell MD
29c. License number: D37291
29d. Date signed (Month, Day, Year): 1/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kari Alperovitz-Bichell MD 134 Owensville Rd West Rive MD 20778

State Registrar

31. Date filed (Month, Day, Year)
32. Registrar's Signature: ▶

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01968

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Delbert Troy Keeling

2. Date of Death (Month, Day, Year): January 11, 2001

3. Time of Death: 0959

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 509-18-2354

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 6/21/1916

9. Birthplace (State or Foreign Country): Oklahoma

Usual Residence of Decedent

10a. State: MD

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10a. Street and Number: 20213 Robinwood Court

10f. Zip Code: 21742

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer

16b. Kind of Business/Industry: Private Industry

17. Father's Name (First, Middle, Last): James F. Keeling

18. Mother's Name (First, Middle, Maiden Surname): Vergie Clark

19a. Informant's Name/Relationship (Type, Print): Patty Sue Bender / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11328 Anne Lane Mercersburg, PA 17236

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Rest Haven Cemetery

Date: 1/13/01

20c. Location - City or Town, State: Hagerstown, MD

21. Signature of Funeral Service Licensee: Robert L. May

22. Name and Address of Facility: Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, MD 21742

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION — 5 days

Due to (or as a consequence of):

b. HYPERTENSION — 4 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. DIABETES MELLITUS

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CEREBROVASCULAR ACCIDENT, BLADDER CANCER

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: 040622

29d. Date signed (Month, Day, Year): JANUARY 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BRADLEY LEVIN CORVIA MD 14236 MEADOW VIEW DR HAGERSTOWN MD

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001

32. Registrar's Signature: Donna B Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Keeling, Delbert Troy

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01969

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary E. Klein
2. Date of Death Month Day Year: January 15, 2001
3. Time of Death: 8:07 AM
4a. Facility Name *(If not institution, give street and number)*: FREDERICK MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: FREDERICK
4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 055-24-3453
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: FEB. 4, 1926
9. Birthplace *(State or Foreign Country)*: ENGLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: FREDERICK
10c. City, Town or Location: FREDERICK
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6850 SNOW GOOSE COURT
10f. Zip Code: 21703
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Navar Marriad 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Giva Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: BOOKKEEPER
16b. Kind of Business/Industry: CRYSTAL MANUFACTURING

17. Father's Name *(First, Middle, Last)*: JAMES (UMN) DOCHERTY
18. Mother's Name *(First, Middle, Maiden Surname)*: MARY (UMN) WILSON

19a. Informant's Name/Relationship *(Type, Print)*: SCOTT L. KLEIN/SON
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6850 SNOW GOOSE COURT, FREDERICK, MARYLAND 21703

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: SMITHSBURG CREMATORY
Date: 1/16/01
20c. Location - City or Town, State: SMITHSBURG, MARYLAND

21. Signature of Funeral Service Licensee: Paul M. Dean
22. Name and Address of Facility: BAST FUNERAL HOME, 7606 Old National Pike, Boonsboro, Maryland 21713

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — Weeks

Due to (or as a consequence of):
b. Chronic Obstructive Pulmonary Disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Tobacco Habituation — years

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
End Stage Renal Failure
Due to Pauci Immune
Glomerular Nephritis

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of Certifier: MD
29c. License number: 047556
29d. Date signed *(Month, Day, Year)*: 1/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM H. JOHNSON MD 172 THOMAS JOHNSON DRIVE, FREDERICK, MD 21702

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 01970

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Izrail Kagan
2. Date of Death (Month, Day, Year): January 21, 2001
3. Time of Death: 6:00P.
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 214-25-8159
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec.24,1925
9. Birthplace (State or Foreign Country): Belarus

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1400 Fenwick Lane, #606
10f. Zip Code: 20910
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chief Civil Engineer
16b. Kind of Business/Industry: Govn't. of Belarus

17. Father's Name (First, Middle, Last): Mosha Leib
18. Mother's Name (First, Middle, Maiden Surname): Chaya Potashnikova

19a. Informant's Name/Relationship (Type, Print): Sarra Savulkina - wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as #10a - 10g

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Judean Memorial Gardens
Date: 1/24/2001
20c. Location - City or Town, State: Olney, Maryland

21. Signature of Funeral Service Licensee: Donald V. Borgwardt
22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Ischemic Cardiomyopathy — 4 years
Due to (or as a consequence of):
b. Coronary Artery Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Frank M. Gravino, MD
29c. License number: D25080
29d. Date signed (Month, Day, Year): JAN/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Frank N. Gravino, MD, 10313 Georgia Ave., Silver Spring, MD 20902

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: Denise B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

ADH
DONA LUKE
01-0030-031

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, II, 27, 28A-F PER MEO G791 1-30-01 WR.

Certificate of Death

Reg. No. 2001 01971

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dona Jean Luke
2. Date of Death (Month, Day, Year): JANUARY 2, 2001
3. Time of Death: 1148 AM
4a. Facility Name (If not institution, give street and number): 18453 LOST KNIFE ROAD
4b. City, Town, or Location of Death: MONTGOMERY VILLAGE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 220-40-3542
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 57 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 07/30/1943
9. Birthplace (State or Foreign Country): Wash., D.C.

Usual Residence of Decedent

10a. State: Md.
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 18453 Lost Knife Circle #303
10f. Zip Code: 20879
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Personal Trainer
16b. Kind of Business/Industry: YMCA

17. Father's Name (First, Middle, Last): Donald Luke
18. Mother's Name (First, Middle, Maiden Surname): Frances Mishata

19a. Informant's Name/Relationship (Type, Print): Karen Burbul, daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2713 Soapstone Drive Reston, VA 20191

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Northern Virginia Crematory
Date: 01/09/00
20c. Location - City or Town, State: Arlington, Va.

21. Signature of Funeral Service Licensee: R deLosto
22. Name and Address of Facility: Old Town Funeral Choices 1205 BelleHaven Rd. Alex., Va. 22307

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): ALCOHOL AND ANTI-DEPRESSANT INTOXICATION
a.
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: DEPRESSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) AT SCENE

27. Manner of Death: 1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year) FOUND: 1-2-01
28b. Time of Injury FOUND: AT 11:48 A M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: SUBJECT INGESTED ALCOHOL AND ANTI-DEPRESSANT
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): FOUND AT HOME
28f. Location (Street and Number or Rural Route Number, City or Town, State): 18453 LOST KNIFE RD., #303 MONTGOMERY VILLAGE, MD

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Stephen S. Radentz, M.D.
29c. License number: OCME
29d. Date signed (Month, Day, Year): JANUARY 3, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Penny G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01972

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James E. Lewis

2. Date of Death (Month, Day, Year): January 1, 2001

3. Time of Death: 11:01 AM

4a. Facility Name (If not institution, give street and number): Prince George's Hospital Center

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 265-54-2582

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 16, 1937

9. Birthplace (State or Foreign Country): Midville, Ga.

Usual Residence of Decedent

10a. State: D.C.

10b. County:

10c. City, Town or Location: Washington

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 603 - 57th Street N.E.

10f. Zip Code: 20019

10g. Citizen of What Country? United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Auto Mechanic/ Supervisor

16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Joseph Archer

18. Mother's Name (First, Middle, Maiden Surname): Lara Mae Lewis

19a. Informant's Name/Reletionship (Type, Print): Harriet Lewis / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 603 - 57th St. N.E. Washington, D.C. 20019

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Harmony Memorial Park

Date: 1/6/01

20c. Location - City or Town, State: Landover, Md.

21. Signature of Funeral Service Licensee: Kenneth George Moore

22. Name and Address of Facility: Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death): a. Hypertensive Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Ceuse (Diseese or injury thet initiated events resulting in death) Lest

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Emphysema

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigetion 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mennar as stated. 2 ☑ **Medical Examiner:** On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Salvador Gloria MD

29c. License number: H00 55327

29d. Date signed (Month, Day, Year): January 5, 2001

30. Name and address of person who completed cause of daath (Item 23a) (Type, Print): Salvador Gloria 3001 Hospital Drive, Cheverly, Maryland 20785

State Registrar

31. Date filed (Month, Day, Year): JAN 08 2001

32. Registrar's Signature: Geneva P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 01973

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LENORA LOWERY
2. Deta of Death (Month, Day, Year): 01-05-2001
3. Time of Death: 14:30
4e. Facility Name (If not institution, give street and number): Prince George's Hospital
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 220-14-3050
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2-14-1915
9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Glenarden
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 2948 Buck Thorn Ct.
10f. Zip Code: 20706
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Datas:
13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+): 1 yr.
16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Pvt.

17. Father's Name (First, Middle, Last): Tommy Gamble
18. Mothar's Name (First, Middle, Maiden Surneme): Sallie Harrison

19a. Informent's Neme/Reletionship (Type, Print): Elaine Grant, Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2948 Buck Thorn Ct., Glenarden, Md. 20706

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Othar (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other place): Harmony Mem. Park
Dete: 1-11-01
20c. Location - City or Town, State: Hyattsville, Md.

21. Signeture of Funerel Service Licensee: Ralph Williams 767
22. Nama and Address of Facility: Ralph Williams Funeral Service 517 11th St., SE, Wash., DC 20003

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complications thet causad the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert failure. List only one ceuse on aech line.

Approximate Interval Between Onset and Death

Immedieta Ceuse (Final disease or condition resulting in death): e. Congestive heart failure — years

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
Due to (or as e consequence of): b. Recurrent myocardial infarction — days
Due to (or es a consequence of): c. Diffeuse coronary atherosclerosis — years
Due to (or es e consequence of): d. Hypertensive Cardiovascular disease — years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: acute or chronic renal insufficiency, Diabetes mellitus Non Insulin dependent anaemia, acute hepatic failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date end piece, end due to the cause(s) and manner es stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: RT Rustagi MD
29c. Licansa number: D 24720
29d. Deta signed (Month, Day, Year): 1-05-01

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): RAVINDER K. RUSTAGI 6132 Landover Road, Cheverly Md 20785

State Registrar

31. Data filed (Month, Day, Year): JAN 0 8 2001
32. Registrar's Signeture: Bonnie L. Sparks

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Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

(3)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01974

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James N. Longus

2. Date of Death (Month, Day, Year): January 8, 2001

3. Time of Death: 9:10 A.M.

4a. Facility Name (If not institution, give street and number): Crescent Cities Center

4b. City, Town, or Location of Death: Riverdale

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-12-6172

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 5/11/14

9. Birthplace (State or Foreign Country): Wash.,D.C.

Usual Residence of Decedent

10a. State: Md. | 10b. County: P.G. | 10c. City, Town or Location: Fairmount Heights | 10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 5602 Kolb Street | 10f. Zip Code: 20743 | 10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Transportation Specialist

16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Norman Longus

18. Mother's Name (First, Middle, Maiden Surname): Edith Williams

19a. Informant's Name/Relationship (Type, Print): Susie Longus/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5602 Kolb St.,Fairmount Heights,Md. 20743

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cem. | Date: 1/13/01

20c. Location - City or Town, State: Washington,D.C.

21. Signature of Funeral Service Licensee: Amy W. Pratt

22. Name and Address of Facility: H.S.Washington & Sons Co.,Inc. 4925 Burroughs Ave.,N.E.,Wash.,D.C.20019

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. ischemic Cardiomyopathy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Renal Insufficiency
Metabolic Encephalopathy

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medicet examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: N Shai M.D

29c. License number: D48213

29d. Date signed (Month, Day, Year): January 8th 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Neelam Ashai 4410 74th AVE landover Hills MD 20784

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001

32. Registrar's Signature: Regina P. Sparks

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Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01975

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MAMIE L. LEWANDOWSKI

2. Date of Death — Month: January Day: 8 Year: 2001

3. Time of Death: 9:35AM

4a. Facility Name *(If not Institution, give street and number)*: 2987 Brinkley Rd., #202

4b. City, Town, or Location of Death: Temple Hills

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-50-8296

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 63 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 12, 1937

9. Birthplace *(State or Foreign Country)*: South Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Temple Hills

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2987 Brinkley Rd., #202

10f. Zip Code: 20748

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: U.S. Postal Service

16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Henry Mungo

18. Mother's Name *(First, Middle, Maiden Surname)*: Mattie Mingo

19a. Informant's Name/Relationship *(Type, Print)*: Kim J. Jackson - Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2987 Brinkley Rd., #202, Temple Hills, MD 20748

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Harmony Memorial Park

Date: 1/13/2001

20c. Location - City or Town, State: Landover, MD

21. Signature of Funeral Service Licensee: John T. Stewart III

22. Name and Address of Facility: Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. metastatic colon Cancer — Due to (or as a consequence of): — ± year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D46246

29d. Date signed *(Month, Day, Year)*: January 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M-ASHRAF MEELA MD WALDORF MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001

32. Registrar's Signature: Regina M. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

CR

4

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01976

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Libby Leitenberg
2. Date of Death (Month Day Year): January 5, 2001
3. Time of Death: 4:45 PM
4a. Facility Name (If not institution, give street and number): Hebrew Home of Greater Washington
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 056-07-9799
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 97 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Sept. 12, 1903
9. Birthplace (State or Foreign Country): Poland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☐ No
10e. Street and Number: 6121 Montrose Rd
10f. Zip Code: 20852
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Hat Maker
16b. Kind of Business/Industry: Clothing

17. Father's Name (First, Middle, Last): Josef Ossofsky
18. Mother's Name (First, Middle, Maiden Surname): Yetta Kraut

19a. Informant's Name/Relationship (Type, Print): Milton Leitenberg/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14720 Seneca Castle Ct. Gaithersburg, MD. 20878

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Beth Israel
Date: 1/7/01
20c. Location - City or Town, State: Woodbridge, NJ.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Arlington Funeral Home 3901 N. Fairfax Dr. Arlington, VA. 22203

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. acute cardio-pulmonary arrest
Due to (or as a consequence of):
b. Coronary artery disease
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Pneumonia / Sepsis
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypothyroidism; Constipation; Hypertension; H/O depression; osteoporosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] Consult Physician
29c. License number: D:44907
29d. Date signed (Month, Day, Year): Jan 5th 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 6121 Montrose Road Rockville, MD 20852 Consult Physician MD

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001
32. Registrar's Signature: [signature]

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ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend # 20b.Per FH PGC 1-12-01 cr

Certificate of Death

Reg. No. 2001 01977

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Lindsay
2. Date of Death: Month January, Day 8, Year 2001
3. Time of Death: 1:05PM
4a. Facility Name (If not institution, give street and number): 6605 Highgate Drive
4b. City, Town, or Location of Death: Ft. Washington
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 237-42-2607
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 68 Yrs. If Under 1 Year: Months, Days. If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Dec. 1, 1932
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Ft. Washington
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 6605 Highgate Drive
10f. Zip Code: 20744
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: African American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Correction/Investigator
16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Leroy Lindsay, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Mattie Hines

19a. Informant's Name/Relationship (Type, Print): Flora Lindsay - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6605 Highgate Dr., Ft. Washington, MD 20744

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans Cem.
Date: 16, 1/15/2001
20c. Location - City or Town, State: Cheltenham, MD

21. Signature of Funeral Service Licensee: John T. Stewart, III
22. Name and Address of Facility: Stewart Funeral Home, 4001 Benning Rd., N.E. Wash., D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Cancer T-Cell Lymphoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. Other: 4 [ ] Nursing Home 5 [✓] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Keith Banton, MD
29c. License number: 17814
29d. Date signed (Month, Day, Year): 1/9/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Keith Banton - 3924 Minnesota Ave., N.E. Wash., D.C. 20019

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001
32. Registrar's Signature: Regina G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 01978

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Leona Margaret Layton
2. Date of Death (Month, Day, Year): January 4, 2001
3. Time of Death: 1542
4a. Facility Name (If not institution, give street and number): 6906 Beacon Place
4b. City, Town, or Location of Death: Riverdale
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-30-6584
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 14, 1925
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Riverdale
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6906 Beacon Place
10f. Zip Code: 20737
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Louis Colie
18. Mother's Name (First, Middle, Maiden Surname): Sadie Dema

19a. Informant's Name/Reletionship (Type, Print): Louis H. Layton, III - Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6906 Beacon Place, Riverdale, MD 20737

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Mt. Olivet Cemetery
Date: 01/08/01
20c. Location - City or Town, State: Washington, DC

21. Signature of Funeral Service Licensee: Donald Dean Dent
22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hypertensive Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Salvador Sylvester DO
29c. License number: H0055927
29d. Date signed (Month, Day, Year): January 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Salvador Sylvester, 3001 Hospital Drive, Cheverly, Maryland 20785

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001
32. Registrar's Signature: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01979

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DWIGHT CARLTON LEESE , SR.

2. Date of Death Month / Day / Year: JANUARY 12 2001

3. Time of Death: 23:46

4a. Facility Name *(If not institution, give street and number)*: MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death: OLNEY

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 217-28-2404

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 68 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 14 1932

9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Olney

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 19436 Olney Mill Road

10f. Zip Code: 20832

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: 1950-1952

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 2

18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales Agent

16b. Kind of Business/Industry: Insurance

17. Father's Name *(First, Middle, Last)*: Gibson Uriah Leese

18. Mother's Name *(First, Middle, Maiden Surname)*: Edna Pearl McDonald

19a. Informant's Name/Relationship *(Type, Print)*: Linda K. Leese / Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 19436 Olney Mill Road, Olney, Maryland 20832

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Sunset Memorial Park

Date: 1/18/01

20c. Location - City or Town, State: Cumberland, Maryland

21. Signature of Funeral Service Licensee: Muriel H Barber

22. Name and Address of Facility: Muriel H. Barber Funeral Home, P. O. Box 5038, Laytonsville, Maryland 20882

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CARDIAC ARREST — 43 minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: b. CORONARY ARTERY DISEASE — 10 years

Due to (or as a consequence of):

c. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ceri Yen

29c. License number: D40970

29d. Data signed *(Month, Day, Year)*: JAN 16 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CERI YEN, KAISER PERMANENTE, 501 N. FREDERICK AVE., GAITHERSBURG 20877

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: Donna B Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

01-0261-033
jhm
JARRELL
MACKS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS# 23 & 27 per ME G792 022801 SS

Certificate of Death

Reg. No. 2001 01980

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jarrell M. Mack
2. Date of Death Month Day Year: JANUARY 15, 2001
3. Time of Death: 22:44 PM
4a. Facility Name (If not institution, give street and number): LAUREL REGIONAL HOSPITAL
4b. City, Town, or Location of Death: LAUREL
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 219-25-6530
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 14 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 7, 1986
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 9080 A Moonshine Hollow
10f. Zip Code: 20723
10g. Citizen of What Country: USA
11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry: None
17. Father's Name (First, Middle, Last): . James Mack
18. Mother's Name (First, Middle, Maiden Surname): Lisa Barry
19a. Informant's Name/Relationship (Type, Print): Lisa Mack/Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9080 A Moonshine Hollow Laurel, Md. 20723
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Memorial Park
Date: 1-22-01
20c. Location - City or Town, State: LANDOVER, MD.
21. Signature of Funeral Service Licensee: J.B. Marshall
22. Name and Address of Facility: Marshall's Funeral home, Inc. 4217 9th St. N.W. Washington, D.C. 20011

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. REACTIVE AIRWAY IN ASSOCIATION WITH RESPIRATORY SYNCYTIAL VIRUS INFECTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: OCME
29d. Date signed (Month, Day, Year): JANUARY 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signature: [signature] G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that this death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 01981

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret Rivens Martin
2. Date of Death (Month, Day, Year): January 6, 2001
3. Time of Death: 2:40 P.M.
4a. Facility Name (If not institution, give street and number): Adventist Sligo Creek Nursing and Rehabilitation Center
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 223-30-3420
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 25, 1923
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: District of Columbia
10b. County:
10c. City, Town or Location: Washington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2000 Upshur Street, N. E.
10f. Zip Code: 20018
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic Worker
16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Wesley Rivens
18. Mother's Name (First, Middle, Maiden Surname): Maude Lee

19a. Informant's Name/Relationship (Type, Print): Shirley Rivens Smith (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2000 Upshur Street, N.E.; Washington, D.C. 20018

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery | Date: Jan. 10, 2001
20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: Kenneth Thom
22. Name and Address of Facility: R. N. Horton Company MOrticians, Inc. 600 Kennedy STreet, N.W.; Washington, D.C. 20011

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Ischemic heart disease
Due to (or as a consequence of): b. Diabetes Mellitus
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension, Valvular heart disease, Hypoglycemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and Title of certifier: Norton Elson
29c. License number: D20362
29d. Date signed (Month, Day, Year): JAN 8, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Norton Elson 6525 Belcrest Rd Hyattsville MD 20782

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 01982

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Louise Wilkes Montague

2. Data of Death Month Day Year: January 5, 2001

3. Time of Death: 10:00 PM

4a. Facility Name (If not institution, give street and number): Mariner Health of Southern Maryland

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 218 16 3365

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): June 14, 1919

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Fort Washington

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2517 Corning Ave #203

10f. Zip Code: 20744

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4 or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): School Aide

16b. Kind of Business/Industry: Prince George's County School Systems

17. Father's Name (First, Middle, Last): Philip James Wilkes

18. Mother's Name (First, Middle, Maiden Surname): Cecelia M. Proctor

19a. Informant's Name/Relationship (Type, Print): Sharon Wilkes Bowden (NIECE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2517 Corning Ave, #203, Fort Washington, MD 20744

20a. Method of Disposition: ☒ 1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans Cemetery — Jan 11, 2001

20c. Location - City or Town, State: Cheltenham, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, Maryland 20735

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Septicemia - Pseudomonas & Staph aureus

Due to (or as a consequence of):

b. Aspiration Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Skin ulcers - Decubiti multiple

Due to (or as a consequence of):

d. Dementia Alzheimer's disease

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Gastric Tube

Intestinal obstruction

HTN - Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: ☒ 1 Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): ☒ 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D 515-20

29d. Date signed (Month, Day, Year): January 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Braham Pishdad, M.D. 1328 Southern Ave, S.E., Washington, D.C.

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01983

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Thomas Eugene Miles

2. Date of Death Month Dey Year: January 4, 2001

3. Time of Death: 5:00 A.M.

4a. Facility Name *(If not institution, give street and number)*: Mariner Health of Southern Maryland

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 579-54-3266

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 57 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: February 24, 1943

9. Birthplace *(State or Foreign Country)*: Washington,D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Largo

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 500 North Harry S. Truman Drive Apt. 102

10f. Zip Code: 20774

10g. Citizen of Whet Country?: United States

11. Marital Stetus: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - Americen Indian, Bieck, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 11th grade; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Newspaper Carrier

16b. Kind of Business/Industry: Washington Post

17. Father's Name *(First, Middle, Last)*: William Henry Miles

18. Mother's Name *(First, Middle, Maiden Surname)*: Clarice Bell Jones

19a. Informent's Neme/Relationship *(Type, Print)*: Clarice J. Miles (mother)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 500 North Harry S. Truman Drive Apt. 102;Largo,Maryland 20774

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland National Memorial Park

Dete: Jan.9,2001

20c. Location - City or Town, State: Laurel, Maryland

21. Signeture of Funerel Service Licensee: Karamech Chem

22. Name end Address of Facility: R. N. Horton Company Morticians, Inc. 600 Kennedy Street,N.W.;Washington,D.C. 20011

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heert feilure. List only one cause on eech line.

Approximete Interval Between Onset and Deeth

Immediete Ceuse (Finel diseese or condition resulting in death)

e. Carcinoma Lung with mid

Due to (or es e consequence of):

Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet Initieted events resulting in deeth) Lest

b. Spread metastasis

Due to (or as e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings evellable prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

28. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and piece, end due to the ceuse(s) end manner as steted. 2☐ **Medical Examiner:** On the besis of examinetion end/or Investigetion, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) and menner steted.

29b. Signeture end title of certifier: Yudh Vir Sahta YUDH V. SAHTA

29c. License number: D0045490

29d. Data signed *(Month, Dey, Year)*: January 8th, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 106IRVING ST. NW SUITE 415 SOUTH TOWER WASH D.C. 20010

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 1 0 2001

32. Registrer's Signeture: Bessie D. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0139-033
crn
Christopher Menciano

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01984

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Christopher U. Menciano
2. Date of Death: Month January Day 08 Year 2001
3. Time of Death: 6:34 P.M.
4a. Facility Name (If not institution, give street and number): 7616 Allentown Road
4b. City, Town, or Location of Death: Fort Washington
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 217-21-8343
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 18 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 9,1982
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Fort Washington
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7616 Allentown Road
10f. Zip Code: 20744
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Asian Specify: Filipino

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry: School

17. Father's Name (First, Middle, Last): Conrado V. Menciano
18. Mother's Name (First, Middle, Maiden Surname): Rosalina Urate

19a. Informant's Name/Relationship (Type, Print): Conrado V. Menciano/Father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as item 10

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 1/13/2001
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: George P. Kalas
22. Name and Address of Facility: George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Hanging
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) at scene

27. Manner of Death: 1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): 01-08-2001
28b. Time of Injury: unknown M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Subject hanged self.
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Yard
28f. Location (Street and Number or Rural Route Number, City or Town, State): 7616 Allentown Rd. Fort Washington, Maryland

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: J. Locke M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): January 09, 2001
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001
32. Registrar's Signature: Donna P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28d-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 01985

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Fritz Mothersole

2. Date of Death (Month, Day, Year): January 10, 2001

3. Time of Death: 0510

4a. Facility Name (If not institution, give street and number): Doctor's Community Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 061-26-6497

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 4, 1930

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland | 10b. County: Prince George's | 10c. City, Town or Location: Berwyn Heights | 10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 7608 Villanova Road | 10f. Zip Code: 20740 | 10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John F. Fritz

18. Mother's Name (First, Middle, Maiden Surname): Catherine Witzel

19a. Informant's Name/Relationship (Type, Print): William L. Mothersole - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7608 Villanova Road, Berwyn Heights, MD 20740

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory | Date: 01/12/01

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☑ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.

29c. License number: H0055927

29d. Date signed (Month, Day, Year): January 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Salvador Sylvester, 3001 Hospital Drive, Cheverly, Maryland 20785

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 01986

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elsie D. Madkins

2. Date of Death (Month, Day, Year): January 3, 2001

3. Time of Death: 1912

4a. Facility Name (If not institution, give street and number): Malcolm Grow Hospital

4b. City, Town, or Location of Death: Camp Springs

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-44-9831

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 7, 1922

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Pricne George's

10c. City, Town or Location: District Heights

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6805 Atwood Street #1

10f. Zip Code: 20747

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic Worker

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Dock Dillard

18. Mother's Name (First, Middle, Maiden Surname): Sallie Turner

19a. Informant's Name/Relationship (Type, Print): Mary Malloy/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1703 Aragona Boulevard, Ft. Washington MD 20744

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removet from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Resurrection Cemetery

Date: 1/10/01

20c. Location - City or Town, State: Clinton, MD.

21. Signature of Funeral Service Licensee: Janice Edwards

22. Name and Address of Facility: Hodges & Edwards Funeral Home, 3910 Silver Hill Road, Suitland MD 20746

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart lailure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Finet disease or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due lo (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end manner as steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end piece, and due to the cause(s) and manner stated.

29b. Signature and litle of certifier: Salvador Sylvester, DO

29c. License number: H00557927

29d. Date signed (Month, Day, Year): January 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Salvador Sylvester, 7001 Hospital Drive, Cheverly, Maryland 20785

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01987

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Franklin Mccrae
2. Date of Death: Month Jan. Day 7 Year 2001
3. Time of Death: 2342 PM
4a. Facility Name (If not institution, give street and number): Prince Georges Hospital Center
4b. City, Town, or Location of Death: Cheverly MD
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 579-74-6310
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 44 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6-16-1956
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 3926 Sunflower Circle
10f. Zip Code: 20721
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bus Operator
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Joseph Radcliff
18. Mother's Name (First, Middle, Maiden Surname): Annie Mccrae

19a. Informant's Name/Relationship (Type, Print): Mary M. Mccrae/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3926 Sunflower Circle Bowie, MD 20721

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: 1-13-01
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Landover, MD 20785

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory failure / ARDS.
Due to (or as a consequence of):
b. Sepsis
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Pancreatitis.
ETOH abuse.
Drug abuse.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: T. A. Mahn
29c. License number: D0055220
29d. Date signed (Month, Day, Year): 1/7/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Terri A. Mahn, M.D. PGHC 3001 Hospital Dr. Cheverly, MD 20785

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01988

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Rose Julia Miller
2. Date of Death (Month, Day, Year): January 10, 2001
3. Time of Death: 8:47 P.M.
4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 236-14-4304
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 20, 1916
9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 917 Cherokee Trail
10f. Zip Code: 21701
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Assembly Line Worker
16b. Kind of Business/Industry: Magnetic Devices

17. Father's Neme *(First, Middle, Last)*: Stanley Stemp
18. Mother's Name *(First, Middle, Maiden Surname)*: Sophia Breski

19a. Informant's Name/Relationship *(Type, Print)*: Joanne Dickinson (Niece)
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 8120 Claiborne Drive, Frederick, Maryland 21702

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Resthaven Mem. Gardens
Date: 1/13/01
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Robert E. Dailey Jr.
22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET STREET, FREDERICK, MD 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	METABOLIC ENCEPHALOPATHY	72 HOURS
Due to (or as a consequence of): b.	AZOTHEMIA	1 WEEK
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	MALIGNANT LARGE CELL LYMPHOMA	2 WEEKS
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PAROXYSMAL ATRIAL FIBRILLATION
TYPE II DIABETES
URINARY TRACT INFECTION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Brian O'Connor, MD
29c. License number: D31761
29d. Date signed *(Month, Day, Year)*: 1/11/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BRIAN M. O'CONNOR MD 501 W. SEVENTH ST., FREDERICK, MD 21701

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001
32. Registrar's Signature: Donna G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01989

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDWARD A. MILLER
2. Date of Death (Month, Day, Year): JANUARY 13, 2001
3. Time of Death: 2:15 PM
4a. Facility Name (If not institution, give street and number): BROOKE GROVE REHAB. & NURSING CENTER
4b. City, Town, or Location of Death: SANDY SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-38-6314
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 20, 1907
9. Birthplace (State or Foreign Country): Michigan

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3330 Leisure World Boulevard
10f. Zip Code: 20906
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Librarian
16b. Kind of Business/Industry: National Library of Congress of Medicine

17. Father's Name (First, Middle, Last): Anton Miller
18. Mother's Name (First, Middle, Maiden Surname): Matilda Peck

19a. Informant's Name/Relationship (Type, Print): James Miller, Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 132 13th Street, S.E., Washington, DC 20003

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: Jan 16, 2001
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Tracy A. Stuart.
22. Name and Address of Facility: DeVol Funeral Home, 10 E. Deer Park Dr., Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA AND SEPSIS — 1 WEEK

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J.E. Howe.
29c. License number: D33700
29d. Date signed (Month, Day, Year): JANUARY 15, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): TED E. HOWE 7542 OVERLOOK DR. BOONSBORO, MD 21713

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01990

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dorothy C. Mahon
2. Date of Death (Month, Day, Year): Jan. 8, 2001
3. Time of Death: 10:53 A.M.
4a. Facility Name *(If not institution, give street and number)*: Homewood Retirement Center
4b. City, Town, or Location of Death: Williamsport
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 164-38-8196
6. Sex: 1☐M 2☒F
7. Age *(In yrs. last birthday)*: 92 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 10-01-1908
9. Birthplace *(State or Foreign Country)*: PA

Usual Residence of Decedent

10a. State: MD
10b. County: Washington
10c. City, Town or Location: Williamsport
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 16505 Virginia Ave.
10f. Zip Code: 21795
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Charles Colgrove
18. Mother's Name *(First, Middle, Maiden Surname)*: Hattie Johnson

19a. Informant's Name/Relationship *(Type, Print)*: James R. Mahon
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 19203 Olde Waterford Rd., Hagerstown, Maryland 21742

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lincoln Cemetery
Date: 1-13-01
20c. Location - City or Town, State: Chambersburg, PA.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Thomas L. Geisel Funeral Home Inc. 333 Falling Spring Road, Chambersburg, PA 17201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia; Cold agglutinin disease

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☒Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D26806
29d. Date signed *(Month, Day, Year)*: January 08, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Audrey Mills 747 Northern Ave Hagerstown MD 21742

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

10:53 AM
1/18/01
DOROTHY MAHON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01991

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Donald Lee Mason

2. Date of Death (Month, Day, Year): January 8 2001

3. Time of Death: 1407

4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214-38-0090

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 58 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 19, 1942

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 16858 Shinham Road

10f. Zip Code: 21740

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4 or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Horse trader

16b. Kind of Business/Industry: horses

17. Father's Name *(First, Middle, Last)*: John Corbin Mason

18. Mother's Name *(First, Middle, Maiden Surname)*: Mildred Arlene Via

19a. Informant's Neme/Reletionship *(Type, Print)*: Alta Nolt Mason Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 16858 Shinham Road, Hagerstown, Maryland 21740

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donalion 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Nama of cemetery, crematory or other place)*: Mt. Zion Mennonite

Data: 1-12-01

20c. Location - City or Town, State: Boonsboro, Maryland

21. Signatura of Funeral Service Licensee: Scott M Minnich

22. Nama and Addrass of Facility: Minnich Funeral Home 415 E. Wilson Blvd., Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximala Interval Between Onset and Death
Immediate Causa (Final disease or condition resulting in death) a.	Respiratory Arrest	2 min
Due to (or as a consequence of): b.	Congestive Heart Failure	3-4 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Myocardial Infarction	> 4 days
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Diabetes Mellitus

23b. Did tobacco use contributs to the cause of death? 1 ☐ Yas 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was en autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Plece of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Menner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicide 5 ☐ Pending Invastigation 6 ☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar es stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jill Ciccarelli

29c. Licansa number: MD0052136

29d. Data signed *(Month, Day, Year)*: January 11, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Ciccarelli 3 Byrkit Drive Williamsport Maryland

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001

32. Registrar's Signatura: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Donald Mason

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01992

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Stewart MILLS
2. Date of Death (Month, Day, Year): January 15, 2001
3. Time of Death: 7:10 a.m.
4a. Facility Name (If not institution, give street and number): 62 E. Franklin St.
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214-09-6463
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 5, 1915
9. Birthplace (State or Foreign Country): Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 62 E. Franklin St.
10f. Zip Code: 21740
10g. Citizen of What Country?: United States
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: W.W. II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): meat manager
16b. Kind of Business/Industry: grocery store
17. Father's Name (First, Middle, Last): Richard Morris Mills
18. Mother's Name (First, Middle, Maiden Surname): Beulah Yeakley
19a. Informant's Name/Relationship (Type, Print): Shirley L. Shirey -daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16627 Kendle Rd., Williamsport, Md. 21795
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rose Hill Cemetery — Date: 1-18-01
20c. Location - City or Town, State: Hagerstown, Maryland
21. Signature of Funeral Service Licensee: Fred L Nuttall
22. Name and Address of Facility: Minnich Funeral Home, 415 E. Wilson Blvd., Hagerstown, Md. 21740

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. lung Cancer — (18) Months.

Due to (or as a consequence of):
b. Chronic Obstructive Pulmonary Disease — unknown.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Coronary Artery Disease — unknown.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD.
29c. License number: D 47288
29d. Date signed (Month, Day, Year): 01-17-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Shaheen Iqbal 12821 Oakhill Avenue Hagerstown MD. 21742

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: D Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01993

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Earlene Owens
2. Date of Death Month Day Year: January 6, 2001
3. Time of Death: 9:30 A.M.
4a. Facility Name (If not institution, give street and number): Gladys Spellman Health Center
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 242-34-1213
6. Sex: 1☐ M 2☐ F XX
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): September 13, 1921
9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Clinton
10d. Inside City Limits: 1☐ Yes 2☐ No XX
10e. Street and Number: 12210 Birchview Drive
10f. Zip Code: 20735
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married XX 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes XX 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes XX 2☐ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic
16b. Kind of Business/Industry: Private Home

17. Father's Name (First, Middle, Last): Boston Richardson
18. Mother's Name (First, Middle, Maiden Surname): Ophealia Wilder

19a. Informant's Name/Relationship (Type, Print): Dewey Hopkins / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12210 Birchview Dr. Clinton, MD 20735

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Ft. Lincoln Cemetery | Date: January 11, 2001
20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ft. Lincoln Funeral Home, 3401 Bladensburg Rd. Brentwood, MD 20722

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Dehydration and Malnutrition	6 months.
Due to (or as a consequence of): b.	Impaired Swallowing Function	Many yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Cerebrovascular Accident	Many yrs.
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia, Parkinsonism, Flexion Contractures.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD.
29c. License number: D31001
29d. Date signed (Month, Day, Year): 1/6/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stuart J. Turkewitz, MD. 7500 Greenway Ctr. Dr. #430 Greenbelt, MD 20770.

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01894

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANN NAVAKOFSKI OST

2. Date of Death: Month JANUARY Day 10 Year 2001

3. Time of Death: 5:25 PM

4a. Facility Name (If not institution, give street and number): HOMEWOOD RETIREMENT CENTER

4b. City, Town, or Location of Death: WILLIAMSPORT

4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 229-44-8818

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 22, 1907

9. Birthplace (State or Foreign Country): WISCONSIN

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WASHINGTON

10c. City, Town or Location: WILLIAMSPORT

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 16505 VIRGINIA AVENUE

10f. Zip Code: 21795

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CROSSING GUARD

16b. Kind of Business/Industry: COUNTY GOVERNMENT

17. Father's Name (First, Middle, Last): THEODORE (UMN) NAVAKOFSKI

18. Mother's Name (First, Middle, Maiden Surname): MARY (UMN) KALINOWSKI

19a. Informant's Name/Relationship (Type, Print): ROLAND E. OST JR./SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2241 HARNEY ROAD, LITTLESTOWN, PA 17340

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): SMITHSBURG CREMATORY

Date: 1/12/01

20c. Location - City or Town, State: SMITHSBURG, MARYLAND

21. Signature of Funeral Service Licensee: P. Steven Danielt Jr.

22. Name and Address of Facility: BAST FUNERAL HOME 7606 Old National Pike Boonsboro, Maryland 21713

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HYPOTHERMIA — 48 Hours

Due to (or as a consequence of):

b. PNEUMONIA — 9 Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEVERE SENILE DEMENTIA

CACHEXIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Medical Director

29c. License number: D 17067

29d. Date signed (Month, Day, Year): 1/11/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STEPHEN E. THOMAS, MD 747 NORTH AVE. HAGERSTOWN, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001

32. Registrar's Signature: Donna P Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0187-031 Amended Item#21 perDVRG792 2/13/2001 EW
mnmr
Bentley Logan Perkins
AMEND ITEM: #23 PART I, 27 PER MEO G791 1-30-01 WR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01995

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Bentley Logan Perkins	January 11, 2001	1148 am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
12905 Falmouth Drive	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
437-92-1963	1 [X] M 2 [ ] F	46 Yrs.			June 19,1954	Louisiana

Usual Residance of Decedant

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
12905 Falmouth Drive	20904	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Yaar or Datas:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highast grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Computer Consultant	Computers

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Logan Irving Perkins	Rita M. Muller

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Elizabeth Warner Perkins/Wife	12905 Falmouth Drive, Silver Spring, MD 20904

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, cramatory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Metropolitan Crematory	Jan 15 2001	Alexandria, VA

21. Signature of Funeral Service Licensee: Andrew J. Cole Jr per DVR

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 Univeristy Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CIRRHOSIS	
Due to (or as a consequence of):	b. CHRONIC ALCOHOLISM	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [X] Yes 2 [ ] No	1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [X] Yes 2 [ ] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) at scene

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J. Aaron Locke, MD	O.C.M.E.	January 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. AARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 17 2001	D. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01996

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lena Adele Patrick

2. Date of Death Month Day Year: January 6, 2001

3. Time of Death: 4:45 PM

4a. Facility Name *(If not institution, give street and number)*: 1505 Redford Drive

4b. City, Town, or Location of Death: Ft. Washington

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-05-9759

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 7, 1914

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Ft. Washington

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1505 Redford Drive

10f. Zip Code: 20744

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Homemaker

17. Father's Name *(First, Middle, Last)*: Alvin Lee Moore

18. Mother's Name *(First, Middle, Maiden Surname)*: Blanche Ball

19a. Informant's Name/Relationship *(Type, Print)*: Barbara Reynolds - Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: Same as #10

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland Veterans Cem.

Date: 01-11-01

20c. Location - City or Town, State: Cheltenham, Maryland

21. Signature of Funeral Service Licensee: ▶ George P. Kalas

22. Name and Address of Facility: George P. Kalas Funeral Home 6160 Oxon Hill Road, Oxon Hill, Maryland 20745

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE — 4 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signeture end title of certifier: ▶ [signature]

29c. License number: D-18545

29d. Date signed *(Month, Day, Year)*: JANUARY 8, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): PC WISEBY MD 12070 OLD LINE CENTER WALDORF, MD. 20602

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 09 2001

32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend # 18,& 19a.Per F.H. PGC 1-12-01 cr

Certificate of Death

Reg. No. 2001 01997

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John S. Prince

2. Date of Death Month / Day / Year: January 5, 2001

3. Time of Death: 7:15PM

4a. Facility Name *(If not institution, give street and number)*: Heartland Nursing Home

4b. City, Town, or Location of Death: Hyattsville

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 576-01-9156

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: September 23, 1914

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Lanham

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 11009 Annapolis Rd.

10f. Zip Code: 20706

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10th | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Building Engineer

16b. Kind of Business/Industry: Government

17. Father's Name *(First, Middle, Last)*: Eddy B. Prince

18. Mother's Name *(First, Middle, Maiden Surname)*: Charlotte ~~Shorlotte~~ Street

19a. Informant's Name/Relationship *(Type, Print)*: Charlotte ~~Shorlotte~~ Tyner/Sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3717 30th Place N.E. Washington, D.C. 20018

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Harmony Memorial Park | Date: 01/11/01

20c. Location - City or Town, State: Landover, MD

21. Signature of Funeral Service Licensee: Debra J. Jenkins

22. Name and Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — 4 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1 [ ] Yes 2 [ ] No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D01852

29d. Date signed *(Month, Day, Year)*: JANUARY 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAUL A. DEVORE MD 4203 Queensbury Rd Hyattsville MD 20781

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001

32. Registrar's Signature: [signature]

ORIGINAL

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

RKD

01-0094-033

KEON

PATRICK AMEND ITEM #27 per ME G794 041901 SS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01998

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Keon Delano Patrick

2. Date of Death Month Day Year: JANUARY 5, 2001

3. Time of Death: 2:10P.M.

4a. Facility Name (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death: CHEVERLY

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 213-53-0951

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 17 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 8,1983

9. Birthplace (State or Foreign Country): Tobago-Trinidad

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Adelphi

10d. Inside City Limits: [X] Yes 2 [ ] No

10e. Street and Number: 9303 - 19th Avenue, Apt. 101

10f. Zip Code: 20783

10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Unemployed

16b. Kind of Business/Industry: NOne

17. Father's Name (First, Middle, Last): Keith Patrick

18. Mother's Name (First, Middle, Maiden Surname): Susan Denese Nelson

19a. Informant's Name/Relationship (Type, Print): Susan D. Nelson (MOther)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9303 - 19th Avenue,Apt.101;Adelphi, Maryland 20783

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bacolet Cemetery/Jan.18,2001

20c. Location - City or Town, State: Scarborough,Tobago-Trinidad;West Indies

21. Signature of Funeral Service Licensee: Karamch Ghan

22. Name and Address of Facility: R. N. Horton Company Morticians, Inc. 600 Kennedy Street,N.W.;Washington,D.C. 20011

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Contact gunshot wound of the head

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequenca of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [X] ~~Pending investigation~~ 6 [X] Could not be determined

28a. Date of Injury (Month, Day Year): 1-04-2001

28b. Time of Injury: Found 2345 M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: subject shot self

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Friends House

28f. Location (Street and Number or Rural Route Number, City or Town, State): 6604 Belcrest Ave. Prince Georges County, Maryland

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stephen S. Radentz, M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): JANUARY 6,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001

32. Registrar's Signature: Geneva G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01999

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George B. Pelleu III
2. Data of Death — Month: January Day: 11 Year: 2001
3. Time of Death: 2233 hrs
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 219-88-9960
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 38 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 9 1962
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedant

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Olney
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 19113 Willow Grove Road
10f. Zip Code: 20832
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedant Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, Give Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired): Sales Person
16b. Kind of Businass/Industry: Retail Hardware

17. Fathar's Nama (First, Middla, Last): George B. Pelleu, Jr.
18. Mothar's Nama (First, Middle, Maiden Sumama): Mildred Desort

19a. Informant's Neme/Ralationship (Type, Print): Mildred D. Pelleu / Mother
19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Steta, Zip Code): 19113 Willow Grove Rd., Olney, Maryland 20832

20a. Mathod of Disposition: 1 ☒ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify)
20b. Place of Disposition (Nama of cemetery, cramatory or othar place): Parklawn Cemetery
Data: 1/16/01
20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licansee: ▶ Muriel H. Barber
22. Nama and Address of Facility: Muriel H. Barber Funeral Home, P. O. Box 5038, Laytonsville, Md. 20882

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha death. Do not anter tha mode ot dying, such as cardiac or raspiratory arrest, shock, or heart tailura. List only ona causa on each line.

Approximeta Intarval Between Onset and Death

Immediete Cause (Finel disaasa or condition rasulting in death)
a. Pneumonia
Due to (or as a consequance ot):
b.
Due to (or es a consequence of):
c.
Due to (or es e consequence of):
d.

Sequentially list conditions, If any, leading to immadiate cause. Enter Underlying Cause (Diseese or Injury that initiated evants rasulting in death) Last

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa givan in Part I.
Ependymoma

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yas 2 ☑ No
24b. Wara autopsy findings available prior to completion of cause of death? 1 ☐ Yas 2 ☑ No

25. Wes casa ratarred to medical examinar? 1 ☐ Yes 2 ☑ No
26. Place ot Death (Check only ona): Hospital: 1 ☑ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Homa 5 ☐ Rasidence 6 ☐ Othar (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accidant 3 ☐ Suicide 4 ☐ Homicida 5 ☐ Panding investigation 6 ☐ Could not be determined
28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, tarm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2 ☐ **Medical Examiner**: On tha basis of examination and/or invastigation, in my opinion, daath occurred at tha time, data and placa, and dua to tha cause(s) and mannar stated.

29b. Signatura and titla of cartifiar: ▶ K R Lillie MD
29c. Licansa number: D53244
29d. Data signed (Month, Day, Year): January 12, 2001

30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print): Katharine R. Lillie, MD 11140 Rockville Pike, PMB 348, Rockville, MD 20852

State Registrar

31. Data tiled (Month, Day, Year): JAN 16 2001
32. Registrar's Signatura: ▶ Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02000

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Isabel Crunkleton Pittman
2. Date of Death Month: JANUARY Day: 9, Year: 2001
3. Time of Death: 1647
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 198-30-2336
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 11, 1920
9. Birthplace (State or Foreign Country): Penna.

Usual Residence of Decedent

10a. Stete: Penna.
10b. County: Franklin
10c. City, Town or Location: Greencastle
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13775 Molly Pitcher Hwy.
10f. Zip Code: 17225
10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager
16b. Kind of Business/Industry: Western Wear Stone

17. Father's Name (First, Middle, Last): Charles S. Crunkleton
18. Mother's Name (First, Middle, Maiden Surneme): Eliza B. Mayhugh

19a. Informant's Name/Relationship (Type, Print): Henry H. Pittman/Husband
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 13775 Molly Pitcher Hwy. Greencastle, Pa. 17225

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, crematory or other piece): Cedar Hill Cemetery
Date: 1/13/01
20c. Location - City or Town, Stete: Greencastle, Pa.

21. Signature of Funeral Service Licensee: ▶ H. Martin Zimmerman Jr.
22. Name and Address of Fecility: Zimmerman And Son Funeral Home Inc. 45 S. Carlisle St. Greencastle, Pa. 17225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Insufficiency — 6 weeks
Due to (or as a consequence of):
b. Pneumonia — 6 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
PseudoAneurysm Aortic Graft
Renal failure. Arteriosclerotic
Cardiovascular disease. Obesity.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, snd due to the cause(s) and manner stated.
29b. Signeture and titleof certifier: ▶ MD
29c. License number: D18127
29d. Date signed (Month, Day, Year): 1/11/01
30. Name snd address of person who completed cause of death (Item 23a) (Type, Print): C. C. Su MD 370 Mill St. Hagerstown Md 21740

State Registrar

31. Date filed (Month, Dey, Year): JAN 12 2001
32. Registrar's Signature: Penny B Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baitimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

PITTMAN, ISABEL CRUNKLETON

DHMH 16 Rev 6/95

ORIGINAL